The implications of adopting a human rights approach to recovery in practice

**Abstract**

This paper proposes a Human Rights based definition of Recovery in response to the differing interpretations of the concept among professionals and people using services. A Human Rights based definition settles the incongruity between the notion of Recovery as a personal responsibility and the notion that Recovery can require professional intervention. Individual practice is considered in the context of the political landscape impacting the delivery of Recovery-oriented support in modern mental health. Practical implications are suggested in accordance with the European Convention on Human Rights, demonstrating that Human Rights are necessarily integral to the principles of Recovery in mental health. It is concluded that when applying this definition of Recovery it is more meaningful to measure the Recovery orientation of professionals and services than to measure Recovery ‘outcomes’ for people using services.

**Defining Recovery**

Since the 1980s the term ‘Recovery’ has been increasingly prevalent in mental health research literature and policy in the USA, Australia, the UK, and other European countries (NICE, 2010; SCMH, 2008; AHM, 2009; CCMHTF, 2003). This has resulted in significant discussion about what Recovery means, how it is experienced, how it can be measured, and how professionals and services can deliver Recovery-oriented support in practice (Frese, Knight & Saks, 2009; Slade, 2009; Silverstein & Bellack, 2008; Ramon, Healy & Ranouf, 2007). Recent literature in the field has repeatedly suggested that the only consensus about the definition of Recovery in mental health is that there is no consensus, and there is commonly confusion and ambiguity around the concept (Aston & Coffey, 2012; Le Boutillier, Leamy, Bird et al, 2011; Ramon, Healy & Ranouf, 2007; Davidson, O’Connell, Tondora et al, 2005; Turner-Crowson & Wallcraft, 2002; Jacobson & Greenley, 2001).

The most commonly identified distinction in Recovery literature is the distinction between ‘complete’ or ‘clinical’ Recovery, and ‘social’ or ‘personal’ Recovery (Barber, 2012; Henderson, 2011). Complete Recovery describes the more traditional medical concept of recovery from mental illness in terms of outcome measures such as symptom reduction, rehospitalisation rates, and adherence to treatment plans (Färdig, Lewander, Melin et al, 2011; Mueser, Corrigan, Hilston et al, 2002). Social Recovery typically refers to social functioning, and whilst clinical recovery can be seen as a sub-section of this (Henderson, 2011; Harrow, Grossman, Jobe et al, 2005; Liberman, Kopelowicz, Ventura et al, 2002) it is not always considered necessary in order for this version of Recovery to be achieved (Provencher & Keyes, 2011; Lysaker & Buck, 2008; Repper & Perkins, 2003). Within the diverse attempts to define social or personal Recovery there exists a further distinction between the notion of Recovery as a process or as an outcome (Silverstein & Bellack, 2008; Bellack, 2006), with some researchers even concluding that it can be considered both a process and an outcome (Liberman & Kopelowicz, 2005).

Generally speaking, professionals and academics attempting to define Recovery have tended to seek outcome definitions, usually with the idea of measuring Recovery outcomes for clinical or research purposes (Färdig, Lewander, Melin et al, 2011; Provencher & Keyes, 2011; Harrow, Grossman, Jobe et al, 2005; Liberman, Kopelowicz, Ventura et al, 2002). Conversely, people with lived experience of being diagnosed with mental illness have tended to conceptualise Recovery as a process unique to the person and as something which cannot be measured or compared across individuals (Romme, Escher, Dillon et al, 2009; Davidson, O’Connell, Tondora et al, 2006; Jacobson & Greenley, 2001; Deegan, 1988).

The proliferation in recent years of personal narratives of Recovery has led professionals to pay more attention to accounts of people’s experiences and to incorporate their perspectives into a professional understanding of Recovery (Amering & Schmolker, 2009). This effort to adapt theories of Recovery in a way that takes into account and values a person’s experiences of mental distress, and does not require symptom reduction as a prerequisite for Recovery, has led to some definitions referring to the notion of Recovery ‘in’ rather than Recovery ‘from’ mental illness. This approach recognises that people can recover from the often devastating effects of being diagnosed with and treated for a mental illness whilst continuing to experience symptoms (Cross, 2012; Slade 2009; Davidson, Schmutte, Dinzeio et al, 2008).

The predominant themes identified in the literature relating to Recovery as a personally defined process of growth and change include: the importance of hope; being believed in; a focus on strengths rather than needs; taking personal responsibility for one’s life; making sense of one’s experiences; developing valued relationships and roles; (re)gaining a sense of self or identity; (re)gaining confidence and control; self-discovery; self-development; living with symptoms (as opposed to being ‘cured’); and acceptance (by self and others) (Tibaldi & Gover, 2012; Romme, Escher, Dillon et al, 2009; Watkins, 2007; Repper & Perkins, 2003; Turner-Crowson & Wallcroft, 2002). However, these themes do not lend themselves easily to empirical investigation, making Recovery difficult to measure in a culture where evidence-based practice is considered essential (Slade, 2009).

**Recovery and Human Rights**

When asking ourselves as professionals how Recovery-oriented our individual practices and services are, perhaps a more helpful alternative is to consider a Human Rights based approach to our understanding of Recovery in mental health. By considering Recovery ‘in’ mental illness in relation to fundamental Human Rights such as liberty, security (EHCR Article 5; 2010) and the freedom of thought (ECHR Article 9, 2010) and expression (ECHR Article 10, 2010), rather than in relation to professionally imposed measures of clinical recovery or social functioning, it may be possible to assess how Recovery-oriented a service or individual practitioner is in relation to the extent to which they empower people using the service to access their Human Rights (Amering, 2012; Frese, Knight & Saks, 2009; Davidson, O’Connell, Tondura et al, 2006).

This approach may be a positive response to the many narratives of people who have used services and argue that Recovery is often a process which takes place in spite of, rather than because of, mental health service intervention (Romme, Escher, Dillon et al, 2009). A Human Rights based interpretation of Recovery emphasises the importance of service delivery prioritising liberty, social inclusion and self-determination in all aspects of support (Frese, Knight & Saks, 2009; Repper & Perkins, 2003). It recognises that a person diagnosed with mental illness may feel that they are recovering as much, if not more, from the consequences of their diagnosis (e.g. stigma, loss of control, iatrogenic effects of treatment) than from the symptoms of illness which originally led to that diagnosis (Sibitz, Unger, Woppmann et al, 2011; Anthony 1993, 1991).

A Human Rights focus recognises that mental illness, and disability in general, is an evolving concept and that disability results from the interaction between people with diagnosed disabilities and attitudinal and environmental barriers which can prevent their full and active participation in society on an equal basis with others (United Nations CRPD, 2006). This position can settle to a degree the tension generated by the notion of Recovery as being a personal responsibility yet still somehow requiring professional intervention. Perhaps we can consider our role as professionals to be facilitating the overcoming of barriers to equality and empowering the people we work with to understand and access their Human Rights.

**Implications for practice**

A Human Rights interpretation of Recovery can be based on the premise that if services are delivered in a way that upholds people’s rights, the other less easily measured themes of Recovery as a personally defined and experienced process or journey, such as hope, acceptance and identity, are likely to follow. A key ethical consideration for the individual practitioner, therefore, is the use of language and the management of the power dynamics between the system, the professional and the person using the service, as well as between different members of a multi-disciplinary team.

In order for us as professionals to gain an understanding of a person’s perspective, we need to value their narratives, emphasising the person’s strengths, qualities and achievements (Watkins, 2007). The role of the professional can therefore be seen as to facilitate the person to tell their story (Hall & Trotter, 2008) rather than to impose their views (or the views of their profession) on the person’s understanding of their experiences. Slade (2009) emphasises the importance of discourse in encouraging and promoting Recovery and using language to describe a person’s strengths and aspirations as a counter-balance to traditional clinical discourse around deficits and disabilities (Davidson & Flanagan, 2007).

As professionals we need to remain constantly diligent and reflective in order to ensure that our approach is genuinely Recovery-oriented and rights based. We can become complacent and feel that we ‘know’ Recovery, or we have ‘done’ Human Rights, assuming that because we have some kind of understanding of what these are we ‘get it’ and are therefore already ‘doing it’. However, when working as part of a larger, inevitably political, structure we need to constantly bring ourselves back to the interaction, ensuring that we are aware of subtle power-play and discourse. The power dynamic between person and professional is to some extent inevitable and difficult to overcome, but we need to acknowledge this power imbalance and address it in order to minimise the potentially damaging impact of power-play on our practice.

A natural starting point for applying these ideas to clinical practice is the assessment process. The language used in an initial assessment informs future professional interpretations and understanding of a person’s experiences, and can therefore shape the person’s identity throughout their journey through the mental health system. We know that people can internalise stigma and judgement by others, and they are particularly at risk of this if they are stigmatised by professionals viewed as ‘experts’.

Hall & Trotter (2008) point out that recovery-oriented, collaborative, person-led assessment is needed to shape and improve people’s experiences of using mental health services. In order for professionals to gain an understanding of a person’s perspective we need to value their rich narratives, emphasising a person’s strengths, qualities and achievements (Watkins, 2007) and assessment needs to be considered an ongoing process rather than a traditional initial assessment informed by the medical model. As mental health nursing is increasingly recognised as a profession in its own right, rather than a subsection of psychiatry, we need to work on developing meaningful psychological formulations through therapeutic interactions instead of considering ourselves as ‘experts’ who ‘do’ assessment to a person as they enter services. Johnstone (2013) has summarised the evidence that team case formulation approaches are positively experienced by professionals and argues that multi-disciplinary team formulations should replace traditional psychiatric diagnosis. The use of formulation as an alternative to, not an addition to, psychiatric diagnosis is also recommended by the Division of Clinical Psychology’s Good Practice Guidelines on the use of psychological formulation (DCP 2011). Assessment should not be a tick box exercise which categorises human experience in terms of psychiatrically defined ‘symptoms’, but a rich and meaningful dialogue enabling a person to communicate their story, facilitated by rather than led by a person with professional training.

**Human Rights in Practice**

This discussion demonstrates that Human Rights and Recovery come hand in hand, highlighting that in order to work in a Recovery oriented way professionals need to uphold people’s Human Rights. This includes all articles of the European Convention on Human Rights (2010) and presented below are two important examples of principles of Recovery oriented support related to articles 9 and 10 (ECHR, 2010), which are particularly relevant in the mental health system. Articles 3 and 5 are then briefly mentioned in relation to the Mental Health Act (1983, 2007).

*Article 9: Freedom of Thought, Conscience and Religion*

By classifying a person’s thoughts and belief systems as “delusional” or “paranoid”, or even by reducing their experiences to “symptoms” such as “anxious” or “depressed”, mental health professionals can undermine a person’s freedom of thought. This is not to say that we ought to “collude” with every individual’s belief system, but that we need to respect people’s beliefs and work within their framework of understanding, rather than imposing our views or the views of our profession on them. Whilst many practitioners in the modern mental health system are willing to explore people’s beliefs in more depth than perhaps has been the case previously, all too often they will then document the content of interactions using psychiatric language, inevitably placing a judgement on the person’s experiences. If we can remember not only to enter a person’s belief system in order to develop a more thorough understanding of their experiences, but also to document interactions in a way that avoids judging their beliefs against some perceived notion of “objective reality”, we can continue to support people through distressing experiences without undermining their Human Rights. It is useful to remember that all experiences, thoughts and beliefs are real to the person, and to consider shared reality in comparison to personal reality, rather than falling back on the common psychiatric distinction between objectivity and subjectivity. All opinions are subjective, including those of the professional.

*Article 10: Freedom of Expression*

Similarly, when professionals document a person’s experiences using professional jargon, we also risk denying them freedom of expression. By translating a person’s expression of their experiences into the language of diagnosis or symptoms we are taking away their narrative and changing their story. This is not to say that professionals should avoid contributing to a person’s understanding of their experiences by working with them and making suggestions, but that psychological formulations should be written collaboratively and the professional should use the person’s own language when documenting what they express.

*Human Rights and Mental Health Law (Articles 3 and 5, ECHR 2010)*

There are certain human rights violations inherent in the British mental health system which it is harder for us to address at the level of individual practice. Article 3 of the ECHR (2010) refers to the prohibition of torture, and a recent United Nations report on torture and other cruel, inhuman or degrading treatment or punishment (2013) states that there are forms of abuse in mental health care that may cross a threshold of mistreatment that is tantamount to torture, including forced psychiatric interventions and detention. The report states that deprivation of liberty (article 5) on the grounds of mental illness is unjustified, yet this remains enshrined in UK law (Mental Health Act; 1983, 2007). The Mental Health Act will need to be examined in light of this report.

**Interdisciplinary Issues**

Taking a Human Rights approach to Recovery within a multi-disciplinary team will inevitably be challenging for the individual practitioner, particularly as we still work in a hierarchical culture dominated by the medical model and by psychiatrists. Many of the systems we work in, and the people we work with, demand diagnosis and pay little attention to psychological formulation as an alternative. By introducing formulation to our individual work with people using services we can bring these ideas to the multi-disciplinary team, representing and communicating the experiences of people we work with in their own language rather than using psychiatric terminology. So rather than attempting to communicate an entire ideology in an abstract way, we can challenge the reductionist paradigm of psychiatry through day-to-day interactions with people using and working in mental health services. It is easy to slip into the habit of using jargon and medical language, contributing to and perpetuating the dominant discourse in mental health, so the individual practitioner needs to be conscious of this risk and regularly reflect on their use of language in documentation as well as interactions with people working in and using services.

**Conclusion**

We are currently working in an evolving mental health system, which despite including Recovery language in its policies and strategies, continues to focus on measurable outcomes. This provides a challenge for the individual practitioner trying to deliver genuinely Recovery-oriented support within the structure of target-driven statutory mental health services. A Human Rights based approach to Recovery inevitably expands the concept to examine society as a whole, rather than particular individuals within society. It involves respecting and valuing individual experiences within the context of larger structural and political constructs of mental health and illness, and can be considered to represent a more radical agenda for the implementation of Recovery-oriented practice in the field of mental health than outcome driven definitions (O’Hagan, Reynolds & Smith, 2012; Amering, 2012; Frese, Knight & Saks, 2009; Ramon, Healy & Ranouf, 2007; Bellack, 2006; Jacobson, 2004). This is not to say that Recovery necessarily needs to begin with large scale structural changes, but that Recovery as individual transformation can result in Recovery as social transformation, and this in turn will create an environment where Recovery is more supported and encouraged as the attitudes of people who use and provide services progress and develop. Inherent to this perspective is the notion that the Recovery-orientation of a practitioner, service or society is not only more easily measured, but also more important to our understanding than measuring the Recovery of individuals using services, either as a process or as an outcome (Burgess, Pirkis, Coombs et al, 2011). As professionals, we need to be examining ourselves and the systems in which we work as much as we examine the people who use the services we deliver.

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