



# Easier to Say ‘Recovery’ than to Do Recovery: Employees’ Experiences of Implementing a Recovery-Oriented Practice

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## Abstract

The aim is to investigate the change towards a recovery-supporting model for health care services in a Norwegian municipality. The model is founded on the five processes identified by Leamy et al. (*British Journal of Psychiatry*, 199, 445–452, 2011): Connectedness, Hope, Identity, Meaning and Empowerment, described as the acronym CHIME. To examine this change, we used focus groups, which provided a basis for qualitative content analysis. The participants were recruited from several departments of the Mental Health and Substance Use unit. We found three themes: reflections on attitudes and actions, patients not participating in matters regarding their situation, balancing paternalistic attitudes and patients’ autonomy. The findings suggest that workers have an understanding of recovery but do not know what to do differently. We advocate that there is a need for tools, mechanisms and structures on *how* to support a recovery-oriented approach for patients needing mental health and substance use treatment.

**Keywords** Recovery · Paternalism · Autonomy · Organizational change · Community services

In 2012, a medium-sized Norwegian municipality decided to merge its services for mental health and substance use (i.e. problematic use of alcohol and illegal drugs) into one unit. During that process, it became clear that mental health and substance use professionals had based their work on different traditions, and therefore, the organisation decided to work towards a joint foundation. That process led to the implementation/systemisation of a recovery-oriented approach. The recovery movement originated in the 1960s as mental health

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patients claimed their rights, including participation in the community, desiring more from their treatment than hospitalisation (Anthony 1993). A recovery approach challenges the established methods by focusing on resources rather than symptoms (Tew 2013).

The existing literature separates the traditional term ‘recovery from’ and the new term ‘recovery in’. The traditional term implies recovery as an outcome and is widely used in physical health services. The new term *recovery* concerns the process of gaining a meaningful life and is not dependent on the status of diagnosis (Slade et al. 2012).

In line with the European Mental Health Action Plan (WHO 2015), the Norwegian Directorate of Health has, through guidelines and policy documents, recommended a recovery-oriented approach that involves a higher level of patient participation in the healthcare sector (Norwegian Directorate of Health 2012; Norwegian Directorate of Health 2014).

Recovery has, with increasing intensity, found its way into the established health and welfare systems in several countries, and Norway began to follow this trend in the mid-late 2000s (Borg et al. 2013). Brekke (2019) explains that recovery has been understood differently in the fields of mental health and substance use, but as more research and experience has been gained, the literature and services have become more aligned. In the beginning, there was a lack of evidence of consistency and/or systematic guidelines for how best to integrate recovery-oriented policies (Brekke 2019). On that basis, there was a need to identify whether employees experienced recovery-based service as being integrated into their workday and whether they could fully understand the phenomena of recovery and provide recovery-based care to their patients. In general, there was a consensus amongst policymakers that recovery-oriented practice was the best pathway for treating people with both mental health and substance use issues (Brekke 2019; Piat and Sabetti 2009).

In the field of mental health and substance use, there is no clear definition of the term recovery. Over time, there has been a growing body of literature that defines and conceptualises recovery; however, no consensus has been reached. According to Shepherd et al. (2008), ‘Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems’. Author (2016) and Biong and Borg (2016) agree that the understanding of the term recovery can differ depending on the context.

In 2011, Leamy, Bird, Boutillier, Williams and Slade conducted a systematic review, finding five processes that participants identified as important in their recovery: connectedness, hope, identity, meaning of life and empowerment (CHIME). This provided an empirically based, theoretical underpinning for (a) recovery-oriented research, (b) mental health professionals to inform clinical intervention, and (c) health service managers to inform organisational policies (Slade et al. 2012). This was relevant for use as a framework for this study’s local community health and social services, as it is manageable and useful for working with patients.

Transforming systems in a complex field such as mental health and substance use demands flexibility and willingness to change and adapt practice (Slade 2015). Although other recovery-oriented practices are known outside of Norway (i.e. [www.imroc.org](http://www.imroc.org)), minimal research is available on how best to make this transition. Therefore, the available literature, which included the paper ‘*Making Recovery a Reality*’ by Shepherd et al. (2008), along with the booklet ‘*100 ways to support recovery*’ by Mike Slade (2009), provided guidelines for the implementation of recovery-oriented services for the unit under study.

## Introducing Recovery in the Unit

All employees from the unit in this study were encouraged to read the articles and information booklets they were provided. Managers were commissioned by the unit leader to reinforce and discuss the information with their employees and address how a recovery approach would change the pace, dynamics and attitudes in the department. Simultaneously, each department elected a recovery contact whose aim was to influence the staff in a more recovery-oriented direction, and each department met regularly for support and to share experiences.

All employees were given a 2-day course in the conversation technique of *motivational interviewing*. Posters of the five important recovery elements and reflection cards were given to each department as an aid for practice and to increase awareness and change attitudes through discussions on recovery issues. Additionally, some departments had team-building events themed on recovery-oriented practice.

In this paper, we intend to examine how the employees contribute to promote the patients' recovery processes and whether through the implementation processes they grasped the concept of recovery. Given the background provided above, we seek to answer this question: How is recovery understood and expressed by the employees after receiving in-unit training on recovery-based services and how do the employees promote recovery in their work?

## Method

We are interested in knowledge about the participants' experiences, which makes a qualitative research method relevant. The data in this study are from four semi-structured focus groups, documenting the interaction between the group members (Malterud 2002). We prepared a few topic questions, such as reflections on their own practice—how decisions are made in a normal workday, the extent to which the patients are involved, and how the participants consider their own recovery support. These focus groups comprise a relevant approach, as they allow discussion to be generated, as opposed to an interview, where the participant may expect to present a 'correct' answer (Malterud 2012).

The focus groups lasted for 1–2 h. The co-researcher, who is a person with experiences with mental illness, participated in all four sessions together with one of the researchers, and the role as moderator was shared between the two. The participants were asked to reflect on their daily practice, their understanding of recovery, their experience of working with a peer worker; a person who has experiences with substance use and/or mental illness, and how/if work habits and ethics have changed since implementing the recovery approach. The focus groups were recorded and transcribed within a week by the researcher.

To ensure validity and reliability, our co-researcher and mentor from the university were present during the analysis and reading of the text. The co-researcher has lived experience as a patient and has wide experience within different user organisations and as a peer worker at a local hospital, which makes her insights unique and valuable to the team. Furthermore, she has a formal education within the health field, which implies that she has knowledge of the field. Her role was to ensure that the patient voice was present throughout the whole process. She also ensured, for the two main researchers, the absence of loyalty to colleagues by highlighting the patient perspective.

## Participants

Participants included in the study were employed for more than 1 year, had more than 30% employment and time and availability to participate. The latter was necessary to ensure that the services in the organisation were unaffected. The employees have a great deal to do and the service users have a right to their services. Leaders were not included, as we wanted a discussion that was not influenced by a leader's presence. In total, 18 people were interviewed.

Peer workers are employed because of their experiences with mental health and/or substance use issues. Peer workers were excluded from the study because employed peer workers were new in the unit and there were only two peer workers employed at the time, which we considered to not be enough to ensure confidentiality. We do realise that we could have initiated measures to ensure their confidentiality and include them in the study, and that we may have missed important information as a result.

## Analysis

The researchers are employed in the unit where the study was conducted, which may bring pre-understanding into the results (Gadamer 1960/2007). To reduce the possible influence of pre-understanding, we included the university mentor and the co-researcher in every area of the study and had regular discussions and reflections on our role as researchers.

For the data analysis, we conducted a qualitative content analysis (Graneheim and Lundman 2004). We initiated the data by reading through the text, followed by thematic structural analyses and identification of meaning units. These meaning units were compared to the first interpretation and sub-themes, and main themes were identified. Following this, in order to achieve a comprehensive understanding, the themes and sub-themes were reflected upon concerning the context and the aim of the study. Throughout the process, we repeatedly returned to the original text to make comparisons and to ensure our understanding. The co-researcher's opinions were particularly relevant in these discussions, as the themes and sub-themes were viewed differently from her perspective. In particular, she identified stigmatising and offensive attitudes, including in relation to non-verbal communication, while the mentor made sure we did not include statements and arguments that we could not support in the data, thereby ensuring reliability.

## Research Ethics

Participants signed a consent form after receiving oral and written information and were notified that they could withdraw from the study at any time. We ensured the participants' confidentiality by not including names or which department they worked in.

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2013 (WMA 2013).

## Findings

We identified three main themes from the discussions.

## Reflections on Attitudes and Actions

The participants described their work situation after participating in training on recovery and were generally positive to the new way of working. The participants explained that the change has made them reflect more on their practice, although they describe that their practice has not changed:

I feel like we are much more aware and reflect more, questioning our decisions. However, I do not feel like we have changed the way we work; we are just more conscious of how we are working.

The changes can be challenging in practice because it seems that the term recovery is difficult to grasp; perhaps it is a bit too abstract. Empowerment and autonomy are identified as being important in the focus groups. However, in practice, the participants' actions do not support the patients' autonomy, and they argue that it is because the patients need such structure. The participants' explanations highlight a discrepancy between their guidelines and their practice:

But it is there, in the back of our minds, this recovery support thought, you know... that they are supposed to make decisions on their own lives. And that we are not supposed to decide anything, but where we work, some patients profit from us coming in and helping them, guiding them and maybe providing them with some structure and that helps them to have better days.

As demonstrated, even with some understanding of the concept of recovery, it is difficult to enact it concretely in practice, which is illustrated by the fact that the participants find it hard to include the patients in their own process.

## Patients Not Participating in Matters Regarding their Situation

Recovery is an active process where the patient's participation is essential. This participation involves shared decision making and the opportunity to manage their own everyday life. A recovery-oriented practice should involve the patients in team meetings about their own situation and include hope and empowerment, which are core elements in recovery. However, it would appear that the patients are not being invited to the meetings where their own goals and dreams are discussed, which is demonstrated in this dialogue:

Participants: 'In our team meetings, we discuss and bring forward new measures that may be of use to the patient.'

'... then we have discussions and reflections within the team about the different patients we serve.'

Researchers: 'Are the patients present in the meetings?'

Participants: 'Oh, no no no, they are not present at our team meetings, they have coordinating meetings they attend'... 'In our team meetings, we discuss opportunities and then present them to the patients, asking for their opinion'

Researchers: 'Could the patients be invited to team meetings?'

## Participants

I do not mean to be patronising, but it is not always sensible to speak freely if a patient is present at a team meeting, you kind of want to protect them. We must choose our words more carefully if a patient is present. I am afraid some sensitive issues would be avoided if a patient was present, just because it may be too heavy for them.

What are they protecting the patients from? Which words can they not say? It seems like the patients need protection from the employees and that the employees have a need to discuss the patients, which is demonstrated in the following quote:

When we are together just the staff, it gets ... then you kind of need to let out ... so we ... there is some making fun of [the patient], because that's a way to vent and loosen up a bit.

## Balancing Paternalism and Autonomy

As shown in the previous section, participants describe that they struggle regarding patients' involvement. Even though the structure seems to be equally paternalistic and recovery-oriented, the employees attempt to reflect a recovery-oriented approach, which creates a disparity between their reflection and action. As demonstrated below, they ascribe that disparity to tradition:

I do not think that we have been good enough on that (involving the patients). Not even close, and it might be about a tradition that we are maintaining ... many years back, right from the start. I cannot really put my finger on exactly what that is. Maybe, if we want that the patient involves him/herself more, we as staff have been way too dominant. If we want services to be more patient-driven, we have a long way to go.

The discrepancy between approach/understanding and action is expressed through the employees' struggle to find their role in relation to the patients, and therefore, they work the same way as they are used to, where, to a large degree, the employees make decisions about the patients. Furthermore, the participants explain that they want to give the patients as much autonomy as they can, regardless of the pressure and expectations from, for example, neighbours or relatives who demand action. However, as the quote below demonstrates, it seems like this autonomy is selective.

But also, to stand, as staff, during the storm from people outside, "oh my god, you have to do something!" without intervening, so what we are doing... we are letting people decide for themselves how they want to dress. If they want to wear a T-shirt with a hole that day, they are actually allowed.

The patients can decide how to dress but are not able to participate in their own treatment process, which is the important matter. Striving towards a recovery-oriented practice where autonomy should dominate, the participants struggle to free themselves from their traditional way of working. The quote below demonstrates that they aspire to give the patient autonomy;

however, it ends up being so limited that the patient is only choosing from alternatives given by the employees.

... Yes, because you bring... there is nothing decided... that's up to the patient... but it is good for the patient to have a few options... what are the alternatives here? So, we have discussed that, and know that it is possible to mention it for the patient, and it is up to the patient if he wants to do what we suggested. So, he has a choice, and that's recovery.

The quote above demonstrates that in reality, the employees are making decisions on behalf of the patients, and the patients are simply being presented with alternatives. The employees have limited faith that patients can realistically make their own choices, and they do intend to protect the patient from unnecessary disappointment, which is exemplified in the following quote:

Sure, it's very difficult when you see that this is very unrealistic. We know that if you set your goals too high ... it becomes ... a disappointment, and negative for the person's self-perspective. So, to have the ability to adjust ... And that it really is the patient who wants to do this ... because we experience that it is not that realistic, because the main goal can be ... say we found that apartment, so now he thinks everything is good ... and we know that it is more difficult than that!

## Discussion

In the focus groups, the researchers and participants explored the five elements of CHIME from Leamy et al. (2011), within the context of enhancing the employees' abilities to support patients' recovery process. The participants expressed increased reflection on their actions, which seemed to be a tool they used to guide themselves towards a more recovery-oriented pathway.

### Reflections on Actions and Attitudes

The participants expressed increased knowledge and reflection about the term recovery and positive attitudes to this paradigm. However, the reflection is on what they already do and how that fits into the CHIME framework, rather than on alternative ways of working. In their reflections, they communicate a dissonance that they feel they should do more but are unsure what.

The participants expressed the importance of elements such as patient involvement, ability to reflect critically and the process of building relationships (Mathisen 2016; Norwegian Directorate of Health 2012). Such terms are not thoroughly described on a governing level, which leaves the different local services to define the content, causing variations of the same term and leading to uncertainty of what terms may imply in practice. Furthermore, the participants explained that they have not experienced a definite change in the concrete tasks they do. However, increased reflection and the resulting increased awareness can be the first step to a dynamic change. As Knutagård (2014) states, employees may think that diffuse changes do not differ from what they already do, even though there may be small differences in nuance that have the potential for significant meaning. For example, it may be complicated

for the staff to comprehend the change and difference in moving from a *patient-centred* approach, which traditionally has meant offering professional assessments of where the important areas of focus are, to an approach that involves working *together with* the patient.

After searching the existing literature, including the scientific literature and government guidelines, we did not find recourses that we felt offered concrete actions on how to support a recovery-oriented approach in local community services. This may be one explanation for why employees are unsure about what exactly they should do differently.

Uncertainties, as described in the section above, can hinder patients' participation in their treatment.

### **Not Participating in Meetings**

The lack of patient participation in team meetings is a habit that is seemingly accepted, despite the fact that for a long time, patients have demanded a 'nothing about me, without me' approach to their care (Slade et al. 2012). The participants argued that the patients may not handle the professional setting in such meetings and that the presence of patients may restrict their professional reflections on their practice, which may lead to less constructive meetings. They expressed a need to protect themselves and the patients. On the other hand, during the focus groups, participants expressed approval for the idea of including patients in meetings, but argued that the function and organisation of the meetings would have to change and effort exerted in order to make it feasible and safe for the patients.

The participants mentioned that they use (gallows) humour to cope and to vent and use the team meetings as an arena for this. This use of humour is a common phenomenon that helps healthcare professionals cope with patients in complex situations, a demanding workload and sleep deprivation, amongst other job frustrations (Aultman 2009; Wear et al. 2009). However, this kind of humour is also used in healthcare settings, deliberately or not, to ascertain dominance or position of power (Aultman 2009).

Patient participation seems to be a challenge, as the need for the employees to be in control of the opportunities they portray to patients may be a barrier to recovery implementation. Reasons for the discrepancy between intention and practice can be that the employees are working towards supporting a recovery orientation, but at the same time, they are afraid of doing something wrong, neglecting their professional responsibility or not doing their job well enough. Having the patients' best interests at heart is a recurring theme in the focus groups, and the participants express a struggle to find balance. The participants argue that they give the patients choices and focus on what they believe to be the patients' needs; however, rarely do they actually ask the patients.

### **Paternalism and Autonomy**

The participants' discussions indicated a tendency to continue acting in a paternalistic manner, even though they identified empowerment and autonomy as important elements. This highlights the difficult balance between paternalism and autonomy.

Although the participants acknowledged that the patients can have a rational conception about themselves, there seems to be an issue with trust and taking this autonomy seriously. Some participants fulfil their duty of 'helping the patients' in the way they personally feel is best and actually believe that the patients profit due to their well-intended actions. According to the definition presented in the introduction, recovery is

what the person defines as a meaningful and satisfying life (Shepherd et al. 2008). Despite having this definition as a guideline, in practice, the participants do not allow the patients to define for themselves what they regard as important. A keystone to recovery-supporting care is to validate and respect self-determination and patient choice, reframing the treatment initiative from the professional's perspective to the patient's perspective (Davidson et al. 2006). Patients who oppose initiatives from the staff can be perceived as 'difficult' (Deegan and Drake 2006; Mathisen 2016). As demonstrated in the findings, the participants attempt to balance the power relations and give patients autonomy, which may lead to a retraction of the employees' own responsibility, using the argument that patients can decide for themselves, despite their serious illnesses. As Manojlovich (2007) and Borg and Kristiansen (2004) describe, a trusting and collaborative relationship with their service provider and a willingness to share power can empower the patient. Thus, working towards patient empowerment and collaborative relationships without a retraction of responsibility may contribute to a better balance in power relations.

### **CHIME—Framework**

The *CHIME* framework, Connectedness, Hope, Identity, Meaning and Empowerment, provides useful information on what patients regard as being important in their own process and what issues the services should focus on. However, the elements are somewhat broadly categorised, with the consequence that a lot can fit into the categories—and into more than one category. For example, pursuing an education is highly relevant within all five categories.

Van Gestel-Timmermans et al. (2010) demonstrate that the CHIME elements influence each other. Raised hope can enhance confidence and thus strengthen the feeling of identity. However, we argue that more research is needed on CHIME processes and tools, especially on *how* to promote CHIME in everyday work, as there is seemingly a challenge regarding how to execute this framework within daily tasks. It is a weakness that such a relevant framework is difficult for the local community services as the unit in this study to enforce.

Brekke et al. (2018) illustrate the potential misuse of recovery approaches as the concept, which was developed by people with lived experience, is seized by the professionals. In the context of this study, this perspective may be expressed through the fact that participants understand the CHIME framework differently from how they attempt to help patients in practice. The health care organisation examined in this study needs to be aware of this pitfall and to continuously have in mind that recovery entails the patients' processes.

### **Methodological Challenges**

Two of the researchers are employed in the same organisation as the participants, which can affect our perspective (Chenail 2011; Malterud 2002). However, we have chosen to conduct the study within our own services, as we can delve deeper into the material and understand what the participants are saying better than if it were an unfamiliar service. Since we had a mentor from the university and a co-researcher who had experiences with mental illness, we claim that we have examined the issue from the relevant perspectives.

In retrospect, we should have prompted the participants to expand on their statements in order to gain more detailed information.

## Conclusions

We suggest that the five main CHIME processes offered by Leamy et al. (2011) are not sufficiently operationalised to make them a natural part of the unit's daily services. These processes have been introduced and presented, and decision-makers have agreed that they should be a focal point for the health care providers in order to offer better services for people with mental health and/or substance use issues. However, there seems to be a lack of tools, mechanisms and structures available on *how* to practically support and implement these processes in specific daily tasks. Additionally, we argue that the CHIME framework should be continuously portrayed and interpreted so the services could better use CHIME as a framework for helping patients.

Furthermore, we emphasise the importance of continuing the recovery training programme, as this enhances the recovery attitudes of the staff (Gaffey et al. 2016). Participants expressed that they are getting familiar with the concept of recovery and welcome it; however, it should be noted that the focus groups were conducted in 2015, when the unit was in the onset period of the large change process.

There is a risk of the health system changing their rhetoric, but not their practice, of which we need to be aware. As shown in this study, it may be easier to say 'recovery' than to do recovery.

This study of the employees' experience in this transition took place in 2016. It would also be interesting to interview the same participants again to examine whether there have been changes during the years since the focus groups described in this paper took place. Additionally, a study where employees from the unit in this study were asked concretely about how they work with the different elements in the CHIME framework would also be relevant.

**Author Contributions** All authors contributed to the study. Data collection was performed by Aasa Kvia, Christel Dahl and Målfrid J Frahm Jensen. Analysis was performed by all authors. All the authors have contributed to the manuscript.

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## Compliance with Ethical Standards

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2013 (WMA, 2013).

This study was approved by the NSD (Norwegian Centre for Research Data) with project number 53682.

**Conflict of Interest** Authors Aasa Kvia and Christel Dahl are employed in the unit where the study was conducted. This is deliberate in studying a process they are part of. Author Målfrid J Frahm Jensen received honorarium for participating in the research from the organisation funding this research. Author Trond Grønnestad has no financial interest regarding this study.

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