

## Supporting evidence for the Recovery Star (4<sup>th</sup> Edition)

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### Introduction

The Recovery Star is a version of the Outcomes Star - a strengths based, person-centred and collaborative tool, for working with people recovering from mental health conditions, whether in hospital, a supported environment or their own home. It has been backed by the Department of Health and is widely used by charities, housing associations, NHS Foundation Trusts and local authorities in the UK, as well as being used in Italy, the USA, Canada and Australia.

This document sets out the research supporting the Journey of Change underpinning the Recovery Star and the inclusion of the ten outcome areas. In addition to this there is also a separate review of the literature on the psychometric properties of the Recovery Star and a report of the collaborative development process. These documents and full details of the Recovery Star are available at <http://www.outcomesstar.org.uk/using-the-star/see-the-stars/recovery-star/>

### The Journey of Change

The Journey of Change (JoC) on which the Recovery Star scales are based consists of five stages that an individual may progress through in their journey towards recovery: 1) Stuck, 2) Accepting help, 3) Believing and trying, 4) Learning and 5) Self-reliance.

The Journey of Change relates well to Prochaska and DiClemente's Cycle of Change in the Transtheoretical model (TTM, 1983) and frameworks tailored for mental health recovery journeys, including Ecological models and the Stages of Recovery model (Andresen, Oades & Caputi, 2003; Onken et al., 2007). The key points of agreement are set out below, but for a full description of how the JoC maps onto other recovery models see Leamy, Bird, Le Boutillier, Williams and Slade (2011).

#### *Moving from "Stuck" to "Accepting help"*

At the first stage on the Journey of Change, the service user is 'Stuck' because they are experiencing strong symptoms but are either unaware of the problem or don't see any way for things to improve. This stage is similar to Precontemplation in the TTM, where individuals are characterised as being 'resistant' or 'in denial', typically lack awareness that the behaviour/situation is problematic and have no intention to take action in the foreseeable future. There are also similarities between the JoC and TTM in that the transition to the next stage ('Contemplation' in the TTM) involves acknowledgement of the problem and openness to information.

Ecological models also emphasise that individuals must first see the need for recovery. Similarly, the Stages of Recovery model begins with 'a time of withdrawal characterized by a profound sense of loss and hopelessness', followed by awareness of the need for change (Andresen et al., 2003; Onken et al., 2007). Acknowledging the problem is often seen as the most important step in recovery (Russell, Lang, Clinton, Adams & Lamb, 2013), and the desire for things to change was identified in 15 studies in Leamy and colleague's review of recovery processes (Leamy et al., 2011).

Since the Recovery Star is intended for service users, the key transition in the JoC is not only acknowledgment of problems but also accepting support from professionals. There is strong evidence that receiving support from others – often professionals, is an important part of recovery (Leamy et al., 2011; Topor et al., 2006).

#### Moving to “Believing and trying”

While there is engagement with support at the Accepting help stage, service users only progress to the Believing and trying stage when they believe that things can improve and that they can play an active role in this. This is similar to the transition to the Preparation Stage in the TTM, in which individuals are described as starting to take small steps towards change and to believe that change is possible.

Recovery is often seen as rooted in this sense of self-agency (Spaniol, Gagne, & Koehler, 1999). Ecological models highlight the development of self-determination and agency (Onken et al., 2007), as does the Stages of Recovery model, which includes ‘starting to work on recovering’ (Andresen et al., 2003). Thirty studies in Leamy and colleagues’ review identified ‘belief in the possibility of recovery’ as a key part of the process, and over 90% of the studies evidenced the role of personal responsibility and taking control (Leamy et al., 2011). While support is still needed at this stage and the next, the service user is no longer passively receiving this support.

Since behaviours are new and individuals are still working things out, they have not yet found what works and things often go wrong. The process of trial and error characterising this stage has been documented in a number of studies (Kartalova-O’Doherty, Stevenson & Higgins, 2012; Leamy et al., 2011). The Recovery Star acknowledges that when things don’t go well this can be due to factors outside of the service users’ control and not having the right support or opportunities, but that at this stage individuals start to believe they can play some part in their recovery.

#### Moving to “Learning”

Individuals progress to the Learning stage when, with support, they begin to find effective ways to manage their mental health and build the life they want. This maps onto the penultimate stage of Rebuilding in the Stages of Recovery model (Andresen et al., 2003), defined as ‘actively working towards a positive identity, setting meaningful goals and taking control of one’s life’. At this stage the individual is learning how to develop resiliency and effectively deal with setbacks with support. According to Andresen and colleagues, ‘the ability to manage a relapse of symptoms – even if this requires the use of hospital services – and a return to the previous state of wellbeing is central to recovery’ (2003, p.973).

Service users often identify discovering keys to well-being’ and preventing relapse as important in recovery (Jensen & Wadkins, 2007; Noiseux & Ricard, 2008). Developing a sense of what works to overcome setbacks also fits with research showing that recovery is often a non-linear process involving making progress, losing ground, and moving forward again (Ralph, 2000b; Tooth et al., 1997).

#### Moving to “Self-reliance”

When individuals move to this stage they can manage well and behave in ways that are positive for themselves and people around them without support from mental health services. This is similar to the Maintenance stage in the TTM and Andresen and colleagues’ final stage of Growth: ‘Living a full and

meaningful life, characterized by self-management of the illness, resilience and a positive sense of self' (Andresen et al., 2003). Restoration of self-reliance is often described as a key goal in the recovery process by service users (Caldwell, Sclafani, Swarbrick & Piren, 2010; Eisenstadt, Monteiro, Diniz & Chaves, 2012).

### **The outcome areas**

The Recovery Star reflects the multifaceted nature of recovery, where adjustments are often needed in a number of areas of an individual's life and there are a wide variety of biological, psychological and social risk factors and protective factors (Leamy et al., 2011; Patel, Flisher, Hetrick & McGorry, 2007). There is increasing recognition of the value of holistic, person-centred care, which is facilitated using the Recovery Star (Hummelvoll, Karlsson & Borg, 2015; NHS England, 2016).

The ten outcome areas were identified as important by service users and professionals involved in the development of this Star and are also supported by the wider body of research described below.

#### **1 Managing mental health**

This outcome area focuses on the individual understanding their mental health and being able to manage their mood, behaviour and symptoms. As discussed above, coping with setbacks is an important part of recovery. As Onken and colleague note: 'recovering from a mental illness clearly entails the development of coping skills and the ability to recognise when to access various resources to sustain one's mental health' (Onken et al., 2007, p14). Coping, resilience and problem-solving in the face of challenges are viewed as key dimensions of recovery (Lieberman, Kopelowicz, Ventura & Gutkind, 2002). In recognition of this, there is increasing interest in self-management programmes, which have been shown to reduce symptom severity, increase confidence, quality of life, and medication adherence (Cook et al., 2009; Davidson, 2005). Appropriate use of medication is included in this area of the Star as it can be a significant contributor to recovery (Melfi et al., 1998; Zygmunt, Olfson, Boyer & Mechanic, 2002).

#### **2 Physical health**

The NHS Five Year Forward View, prioritises addressing the higher risk of poor physical health in those with mental health conditions (NHS England, 2016). This is important because mental health has a strong interrelationship with lifestyle factors such as diet, exercise, and sleep (Van Citters et al., 2005). This outcome area includes these issues as well as safety and receiving treatment.

There is strong evidence that exercise can improve mental health, alleviating symptoms associated with depression, anxiety disorders and schizophrenia, including secondary symptoms such as low self-esteem and social withdrawal (Richardson et al., 2005). Two reviews of the literature reported large reductions in depressive symptoms as a result of increased exercise, with benefits equivalent to those produced by standard psychotherapeutic interventions (Craft & Landers, 1998; Lawlor & Hopker, 2001). There is also evidence that interventions addressing healthy eating and sleep quality can improve mental health functioning (e.g., Tanaka & Shirakawa, 2004; Van Citters et al., 2005). More generally, managing stress and engaging in enjoyable activities produces benefits for both physical and mental health (Grossman, Niemann, Schmidt & Walach, 2004), so this is also included in this area.

### 3 Living skills

This area addresses basic living skills such as shopping, cooking, cleaning, washing, dressing, and managing money. There is evidence that having these skills to live independently is key to mental health (Baxter & Diehl, 1998; Liberman et al., 2002). One of the skills included in this outcome area is being able to manage money, which has been associated with greater quality of life, confidence in one's abilities and fewer hospitalisations (Elbogen, Tiegreen, Vaughan & Bradford, 2011). Living skills programmes are often part of the rehabilitation process and there is evidence that they can reduce symptoms and support reintegration (e.g., Dilk & Bond, 1996). Several studies have found that people who receive skills training are able to live more successfully in the community than those receiving standard care (Anzai et al., 2002; Bartels et al., 2004; Grawe, Falloon, Widen & Skogvoll, 2006; Kopelowicz et al., 2003; Moriana, Alarcon & Herruzo, 2006). Having adequate language skills is also included here because this can also be an important part of community integration and reducing isolation – indeed, English classes are one of the key factors identified by non-native speakers as key to their recovery (NAAPIMHA, 2002).

### 4 Friends and social community

This area includes friends, social life and activities, social skills, connection and belonging. Having supportive social connections and being able to participate fully in the community have been identified as core indicators of progress towards recovery (Johnson, 2000; Liberman et al., 2002). Research shows that regaining social roles that were lost or creating new roles strongly contributes to recovery (Ahern & Fisher, 1999; Miller, 2000; Tew et al., 2011). This may even be a necessary component of recovery, with one review stating that 'supportive social relationships, circumstances, and opportunities *must* be in place for recovery to be fully actualized' (Onken et al., 2007, p.16). For some people, social skills training can be helpful in creating or improving social relationships, and such training has been shown to reduce psychiatric symptoms (Dilk & Bond, 1996). Social support and feeling part of the wider community can also contribute to mental health by fostering a subjective sense of belonging, meaningfulness and self-esteem (Prince & Gerber, 2005; Thoits, 2011). It can also act as a buffer against the harmful impacts of stressful situations (Thoits, 1995).

### 5 Use of time

Work has been described as greatly enhancing 'people's sense of self-worth, not to mention their ability to be independent' (Chamberlin & Rogers, 1990, p.1242), and working or studying in positive settings is an important aspect of recovery (Liberman et al., 2002). Work and training can bring financial, social and emotional benefits (Roberts & Wolfson, 2004), and provide 'a context for establishing and maintaining not only instrumental but also intimate relationships' (Rüesch et al., 2004, p. 692). Taking part in work, training or study also allows people to perceive themselves positively as 'active workers' rather than 'passive patients' and to feel connected within the community (Borg & Kristiansen, 2008, p. 517). This outcome area therefore covers training, volunteering and suitable and satisfying work.

Having a sense of purpose and interests is also included in this outcome area as meaning can be derived through other purposeful activities (Onken et al., 2007). Qualitative research found that people with severe mental health problems wanted 'to do more, whether it was paid work, volunteer jobs, school, or leisure pursuits' (Nagle, Cook & Polatajko, 2002). These enriching or meaningful activities can enhance coping and lead to a reduction in symptoms (Ahern & Fisher, 1999; Baxter & Diehl, 1998; Lapsley et al., 2002).

## 6 Relationships

This outcome area focuses on close relationships, rather than the wider social connections addressed in Friends and social community area. These areas can be interrelated for example, intimate relationships can be helpful in maintaining wider social networks (Salokangas, 1997), but there may also be issues within close relationships and not wider networks or vice versa and having a supportive network does not buffer the effects of being single or unhappily married (Holt-Lunstad, Birmingham & Jones, 2008).

People with mental health issues often have fewer close relationships (Macdonald, Sauer, Howie & Albiston, 2005) and addressing this is often key to recovery (Andresen et al., 2003; Baxter & Diehl, 1998). Having one or more personal relationships that provide hope and encouragement greatly improves recovery (Spaniol et al., 2002). People who have supportive and equal relationships and who participate in the community also tend to have 'increased control over daily life' (Nelson et al., 2001, p. 131). Research shows that the quality of the relationship is important, with research suggesting that single individuals fare better than those who are unhappily married (Holt-Lunstad et al., 2008). In line with this, this outcome area refers to having 'satisfying close relationships' that are 'working for you'.

## 7 Addictive behaviour

This area covers **drugs, alcohol, gambling and other addictions**. There is evidence that addictive behaviours including problem drinking, gambling, shopping and drug use are more prevalent among those with mental health needs than the rest of the population (Kessler et al., 1996; Schlosser, Black, Repertinger & Freet, 1994; Shaffer & Korn, 2002). This link is likely to be in part a consequence of self-medicating in an attempt to cope with trauma and emotional pain (Grüsser & Thalemann, 2006; Khantzian, 1997). Unfortunately, addictions also lead to poorer mental health outcomes (Swartz et al., 1998). For example, problem drinking, and drug abuse are associated with multiple readmissions to psychiatric hospitals (Carpenter, Mulligan, Bader & Meinzer, 1985). Problem gambling is also included in this area because it is associated with a significant burden of harm relevant to mental health including debt, legal problems, decreased work productivity, relationship problems, ill health and depression (Blaszczynski & McConaghy, 1994; Dickerson, Hinchy & England, 1990; Lesieur & Blume, 1991; Lorenz & Yaffee, 1988; Productivity Commission Report, 1999; Taber & Chaplin, 1988). Research has also shown that substance abuse is associated with failing to engage with medication and aftercare (Osher & Drake, 1996; Owen, Fischer, Booth & Cuffel, 1996).

## 8 Home

This outcome area covers having a secure and adequate home, avoiding eviction, feeling at home and respecting others. These issues are important in the context of mental health because without suitable housing, people have 'little chance of maintaining other resources in their lives, such as supportive social relationships and meaningful activities' (Browne, Hemsley & St John, 2008). Service users identify secure and adequate housing as an important factor in their recovery (Borg et al., 2005; Kyle & Dunn, 2007), and as a place for growth, control and a means of balancing the need for social contact and for privacy (Borg et al., 2005). However, many people with a mental health diagnosis live in substandard accommodation (Kyle & Dunn, 2007), and those with schizophrenia and other major psychiatric disorders are at much greater risk of homelessness and housing instability (Caton & Goldstein, 1984; Link et al., 1994). Unstable housing arrangements can sometimes be a result of failing to abide by the rules in supported accommodation (Padgett, Gulcur & Tsemberis, 2006). Improving housing situations can be very beneficial to recovery, with

positive effects on mental health outcomes and social participation (Thomson, Petticrew and Morrisson, 2001; WHO, 2004a; WHO, 2004b).

## **9 Identity and self-esteem**

This area includes self-worth, identity and self-advocacy, and is important because mental health crises can dislocate an individual's sense of who they are and how they are seen by others (Pettie & Triolo, 1999), with their identity often becoming defined by the diagnosis (Mancini, 2007). Rebuilding self-esteem and a positive identity is therefore a pivotal task in the recovery process (Lieberman et al., 2002; Onken et al., 2007; Pettie & Triolo, 1999). The process of rebuilding self-esteem and a positive identity hinges on developing a more holistic sense of self and reducing the damage caused by stigmatisation (Mancini, 2007; Ridgway, 2001). This is a collaborative process that occurs alongside family, friends and service providers (Harding & Zahniser, 1994).

Self-esteem is also included because it is not only a basic feature of mental health, but also helps protect against negative influences and promotes healthy functioning in other areas (Mann, Hosman, Schaalma & de Vries, 2004). It also makes it easier for people to self-advocate in rehabilitation settings, actively seeking information and communicating effectively (Jonikas et al., 2013). Self-advocacy is also included because there is increasing recognition of the importance of patient self-advocacy, with research linking it with indicators of recovery such as hopefulness, reduction in psychiatric symptoms, and willingness to engage in services (Jonikas et al., 2013; Loh et al., 2007).

## **10 Trust and hope**

This area focuses on 'Faith in yourself, in others and in life, a sense of meaning'. Hope, spirituality and empowerment are key factors in mental health recovery (Schrank & Slade, 2007). A sense of hope is essential to rallying the resources needed to overcome mental health challenges (Onken et al., 2007), and can often propel people to take steps towards improving their situation (Jacobson & Greenley, 2001; Lunt, 2000). For some people, spiritual beliefs and trust in God can instil hope, purpose and meaning (Mohr, Brandt, Borrás, Gilliéron & Huguelet, 2006).

Faith in others is included in this area supported by many accounts of recovery which stress the importance of encountering hope and optimism in treatment and service provision (Andresen et al., 2003). This is an overarching principle in clinical guidelines (National Institute for Clinical Excellence, 2002). It is also important that service users trust mental health providers, family members and others to be open to the possibility of moving beyond the constraints of mental health issues (Ahern & Fisher, 1999).

## **Conclusion**

In conclusion, there is a strong evidence base supporting the inclusion of the outcome areas as areas of need, and the transitions described in the Journey of Change, with the potential to strongly contribute to recovery.

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