Barriers and Enablers of Recovery Oriented Practice

Barriers

Recovery-oriented practice can be successfully implemented when it is seen as an organizational priority, leadership strongly supports it, and staff members are trained and well versed in the tools and experiences that can enhance personal recovery.

Although organizations may have the best of intentions with establishing recovery-oriented practice, specific and enduring barriers can significantly impede the implementation of practice guidelines, if not addressed. Most barriers relate to competing priorities (summarized in Table 1) or stigma.

Table 1. Competing Priorities[1]

Barrier	Competing Priority	Example Mitigation Strategy
Health Process Priorities	Mental health continues to be dominated by clinical language and tasks, hierarchical power imbalances, and the obligations of risk management.	**Job descriptions and performance management** must include recovery-oriented practices to help create the expectation that these are part of the role.
Business Priorities	Financial concerns and government funding priorities are often at odds with recovery-oriented practice or they emphasize process indicators (such as length of stay or visit volumes), not impact.	Prioritize and seek out funding opportunities that involve individuals with lived and living experience of mental health problems or illnesses and/or substance use. Demonstrate impact by collecting recovery outcomes and other indicators that make the **business case for recovery**, including community integration, readmission, staff retention, etc.
Staff Role Perception	Staff do not necessarily see recovery (or sharing and connecting on a human level) as a function of their professional role. This choice is often dictated by an individual's personality or values.	It is important to **recruit and select staff** who are open to delivering services differently and are comfortable empowering service users to choose their own path.

[1] Le Boutillier, C., Slade, M., Lawrence, V., Bird, V. J., Chandler, R., Farkas, M., Harding, C., Larsen, J., Oades, L. G., Roberts, G., Shepherd, G., Thornicroft, G., Williams, J., & Leamy, M. (2015). Competing priorities: Staff perspectives on supporting recovery. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(4), 429-438. https://doi.org/10.1007/s10488-014-0585-x

Stigma

Stigma in mental health continues to be a barrier in the implementation of recovery-oriented practice guidelines. Sometimes, mental health practices are taken for granted and health-care professionals do not immediately recognize them as stigmatizing. For example, in mental health hospitals, access to the outdoors, or to one's own money or food, may be deemed a "privilege." This type of **structural stigma** requires acknowledgment and correction. Collaborating with individuals who have lived and living experience, either through co-production or by hiring them as experts, can greatly enhance recovery initiatives and challenge stigmatizing practices.

Enablers

Co-production and Lived Experience

Co-production allows service users to participate in the recovery process by providing input and additional perspectives on the features and delivery of treatment. It positions people with lived and living experience of mental health problems and illnesses and/or substance use as experts by the fact of that experience, while empowering them to share it. In addition, co-production helps to challenge stigma by reducing the power hierarchy inherent within the medical model. Organizations can leverage co-design to build a common language, shape the physical environment (and access to it), develop programming, and share decision making.

To successfully apply a recovery model, the facility must recognize the issue, identify the problem, and create a solution. Consider the following examples that could benefit from incorporating the lived and living experience of service users.

- **Access**. Often, service users are not given the same access to physical spaces as service providers. For example, badges or swipe cards can limit access and create a power imbalance between them. When possible, physical space should be accessible to all persons who are using the space. Such access enhances service users' sense of inclusion and self-determination, and it reduces the use of compliance and privilege.
- **Language**. The language used in connection with service users may not recognize their humanity; for example, using phrases such as "patient" or "is bipolar" (instead of "a person who has bipolar disorder").
- **Environment**. Services should be offered in a safe, accessible space that has a feeling of community rather than the sense that it exists solely to treat illness. Service environment policies should include mechanisms for flexible rules that are more like normal citizenship entitlements.

Leveraging lived and living experience can be used to

- establish a more person-centred culture of care
- provide peer support
- inform education and training for staff
- create action plans that support recovery
- develop and deliver recovery-related initiatives
- generate policy
- craft a strategic plan and vision.

Start by participating in **a Trialogue event**.