

It is possible for people diagnosed with schizophrenia to recover

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Abstract: *Services that support individuals with a diagnosis of Serious Mental Illness are called upon to deliver services that seek to promote their recovery. The National Institute for Mental Health in England (NIMHE, 2005), have been working towards defining the key features of what a recovery oriented service should look like. Optimistic as it may seem, services are a long way to undoing the effects of institutionalisation in the lives of many service users. This article provides an account of an evaluation of a Recovery Group designed to introduce participants to the recovery paradigm, in an attempt to help enhance their hopefulness about their future. It was hypothesised that when people are hopeful about achieving their goals, then they will become more motivated to pursue meaningful activities. An eight week group was conducted using outcome measures such as the Beck Hopelessness scale (1974), Lancashire Quality of Life scale, Bradburn Affect Scale and Cantill's Life Ladder. Seven mental health service users from a Rehabilitation Inpatient Unit, and Community Team participated in the Recovery group, of whom four service users completed the programme. Despite methodological limitations of this evaluation some improvements were noted for the service users in terms of improved quality of life, a sense of optimism for the future and improved psychological well-being.*

Key words: *recovery; quality of life; well-being; mental health; social support; coping strategies.*

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Introduction

Historically, individuals with a diagnosis of serious mental illness were seen as being unlikely to recover (for example, Wahl, 2003; Perlick and Rosenheck, 2002). As a consequence, service users have been viewed as being unable to take control of their lives, hence the need for continuing care services.

Research has found that this assumption of a state of permanence has had negative implications for the mental health service user in terms of exclusion from work (Fisher, 1998) a decent chance in life and respect (Department of Health, 2001; Markowitz, 1998). The damaging effect that this has had on some individuals is that they have given up hope of any prospect of achieving their aspirations in life, leading to reduced levels of self-esteem and quality of life (Link et al, 2001). Evidence has also found that as a result of societal negativity, mental health service users are at greater risk from suicide (Agerbo et al, 2001; Roy, 2001).

More recently, the Department of Health have embraced the more optimistic philosophy of recovery, which has emerged from the service user movement, outlined in their document *The Journey to recovery* (2001). In it, the possibility of recovery is highlighted for the majority of people, and it recommends that services of the future need to talk as much about recovery as they do about symptoms and illness.

Recovery from what is said to be mental illness has been defined as controlling 'symptoms', regaining a positive sense of self; dealing with stigma and discrimination and to maintain a productive and supportive life (Deegan, 1996; Markowitz, 2001). Research has found recovery to be a real experience with service users (Drake et al, 2002; Fisher, 1999; Neeleman et al, 2003; Sabin & Daniels, 2003; Torgalsbøen, 2001). This clearly challenges the view that people with a diagnosis of serious mental illness are unlikely to recover (Whitwell, 1999).

Evidence has found that in order to achieve substantial improvements in recovery from mental illness an important mechanism concerns the nature of social support given to individuals (Neeleman et al, 2003). These aspects include:

- The encouragement of hope for a better future.
- Life roles with respect to work and meaningful activities are defined.

- Spirituality is considered.
 - Culture is understood.
 - Educational needs as well as those of significant others are identified.
 - Socialisation needs are identified.
 - They are supported to achieve their goals.
- (Fisher, 1999; Meade and Copeland, 2000; Schmook, 1996).

Groupwork is described as a potentially integrating experience because it connects the universal experience of being human. That is, it satisfies a need and desire for the company of others (Doel and Sawdon, 1999). Groupwork has been found to be a beneficial forum to offer social support to mental health service users in terms of providing understanding, hope, reassurance, encouragement and practical coping techniques between appointments (Murray, 1996; Recovery Inc. 1995). Indeed mental health service users reported group strengths as: feeling supported and understood, being able to speak freely without staff reprisals, obtaining information and feedback, improved mood, and decreased drug use (Felix-Ortiz et al, 2000). Furthermore, a self help organisation found that service users who are part of a recovery group have improved clinically in comparison to service users who are not part of a recovery group (Recovery Inc., 1995).

In an attempt to build on previous work, and to raise awareness about the recovery paradigm, mental health service users were invited to participate in a recovery group. The broad aims of the group were to help increase:

- Their hopefulness about achieving their future aspirations.
- Their motivation to pursue life goals.
- Their motivation to improve their degree of quality of life.
- To provide a supportive forum

A curriculum based approach was adopted as the model of choice because the group was time limited, so the emphasis was to offer a more focussed intervention, and encourage the continuous evaluation of practice (Galinsky et al, 2007). The primary focus of the group was to work with individuals in a group setting, but also to help group members share experiences of what has been working for them and to find ways that they could learn from one another.

Setting up the group

Service users who were being supported by a Recovery Rehabilitation and Continuing Care Service were invited to join the group. The service comprises inpatients and patients who live in the community. Those who resided on the ward were told about the group during a weekly ward community meeting, where daily activities within the ward are discussed, and those who live in the community were told about the group by their care co-ordinators. In addition, flyers were posted up on the walls of the ward. Potential respondents were given an explanation into the background of the group and its purpose and aims, and informed that it was a closed group.

A total of seven people attended the first group meeting, although by the end of the intervention, only four people had completed the programme. One person was discharged to another area outside of the team's catchment area, and two people were later transferred to another ward.

The Core group members

Peter

Peter was 39 years old and of English heritage. He worked for the Home Office 14 years ago, just before his first admission into hospital. He was a very articulate man, and his presenting complaint was chronic compulsive and checking behaviour. His immediate goals were to develop the confidence to go on holiday and long term he hoped to get well again, meet a girlfriend, and secure accommodation in a hostel.

John

John was 40 years old and of English heritage. He lived with his parents before coming into hospital, and has never worked. He has been a user of psychiatric services for over 20 years. He was very articulate and had a diagnosis of schizophrenia. Recovery for him, was to be able to stay out of hospital

Mangit

Mangit was 29 years old, of Asian origin. He has been a user of psychiatric

services for 12 years. He has a diagnosis of depression, and has made several attempts to commit suicide in the past. He presents very well, and has been able to secure employment in recent years. His jobs have been rather short lived, however, because of his frequent breakdowns. His long term goal is to secure a job in project management.

Sam

Sam was a 30 year old man of English heritage. He has been a user of psychiatric services for 11 years. He has a diagnosis of severe depression, and has had frequent admissions into hospital over the past few years. His long term goal is to eventually secure a job as a psychiatric nurse.

The group programme

The group was designed by one of the authors. The content of the programme was devised to introduce participants to psychological concepts and principles to reinforce and to encourage recovery. The definition of recovery which underpinned the group programme was: To develop appropriate supports and coping mechanisms to be able to deal with mental health experiences rather than being given supports by mental health services (Baker and Strong, 2001). Therefore recovery in this context means ... instead of focussing on symptomatology and relief from symptoms, a recovery approach aims to support an individual in their own personal development, building self-esteem, identity and finding a meaningful role in society (Jacobson and Greenly, 2001). Recognising that, the recovery paradigm continues to go through the process of moving from rhetoric to practice. The group aimed to empower individuals to learn to stand up for their rights as part of the day to day of receiving care from the mental health service.

Given that this was the first group to be run within the service, and the emphasis was to assess for the potential benefits of the group, a time limited format was adopted. Given its time limited nature, the group was designed to focus on the process of ending, so early on home work techniques were employed in order to help group members to transfer their learning to the real world (Doel and Snowdon, 1999). There were eight 90 minute weekly sessions and the programme is outlined as follows:

1. Finding out where you're at

Group members (including the facilitators) took it in turns to introduce themselves and to describe a little bit of what they hoped to gain from the group. A dominant expectation from the members, was that of hopefulness for an improvement in their circumstances. Group members spoke very freely about receiving a history of negative discourse about their condition, and a feeling of being stuck in the psychiatric system. They highlighted that the flyer they had read about the recovery group presented a more hopeful offer to what they had been used to, and they were curious to come and find out more.

Ground rules such as confidentiality, and respecting the opinions of others were established.

The concept of recovery was introduced to the group members, as well as the policy context (DOH, 2001). Group members were given the opportunity to reflect on how it was relevant to their situation. Most people were pleased to hear about how services were supposed to be going, but highlighted that their experience within the current service on a day to day basis seemed very far behind what the recovery ideas were advocating.

They were invited to engage with an outcome measurement process as a means to help them measure whether the group provided them with any benefit over time.

2. Feedback of where you're at

Group members were given a copy of their results from the questionnaires to discuss with the group. They appeared pleased to receive this, as it seemed to provide a sense that the reasons for why they joined the group were kept very much on the agenda. A lot of discussion was generated around the extent to which they agreed with the information, and whether it fitted with how they were feeling about their lives presently. For example, if a person scored highly on the Beck Hopelessness Scale, this was fed back to them and some of the reasons for this explored.

3. A Model of Recovery

A video was presented to the group entitled 'Recovery is for everyone' by Dr Daniel Fisher. Daniel Fisher is a psychiatrist, who suffered a breakdown whilst he was studying medicine, which led to an admission into a psychiatric hospital. Throughout the video he charts

his experiences of psychiatric care. He has drawn primarily on his own experiences to arrive at a model of recovery.

The model described the dimensions of the self that needs to be fulfilled in order for an individual to feel as if they are in recovery. These dimensions were: having a social network, having a voice, having a sense of purpose, being hopeful about the future, belonging to a community, and having shelter. He then presented the coping strategies that he used to aid his recovery.

Group members were then invited to reflect on what they heard, and some felt able to draw parallels between the model and their own lives. This discussion, led to the formulation of individual coping strategies that they found helpful during difficult times.

4. Group discussion on coping strategies

Following on from the previous week, Group members were encouraged to reflect on additional aspects from the video. They were also given the opportunity to revise their coping strategies from last week. Discussion centred around how useful they may have been to them during the week. Peer discussion was encouraged whenever a group member needed help to problem solve.

5. Developing personal recovery profiles

Empowerment is seen as a core dynamic in promoting recovery. There is increasing awareness of the value of detailed self-management strategies that help individuals to take control of their own experience and their lives (Repper and Perkins, 2003). Group members were encouraged to identify what they found helped them overcome difficult times, and what enabled them to gain mastery over their lives. Individual profiles were written up as a plan, so that group members could have easy access to the actions, thoughts and behaviours that are associated with staying well.

6. Putting strategies into practice (Part I)

Group members were invited to consolidate the use of their recovery tools. This was in order to encourage them to pay attention to what it is that helps them to stay well rather than to what doesn't. If group members were not able to think of immediate examples, they were encouraged to reflect on when they felt well in the past, and try to

identify what it was that they found helpful. They offered one another support whenever they wished to discuss areas of concern.

7. Putting strategies into practice (Part II)

Group members were encouraged to provide more feedback to the group about how they were able to put their identified coping strategies into practice, and to offer one another support whenever they wished to discuss areas of particular concern.

8. Ending

To support group members to think about how they will continue to put their recovery strategies into practice once the group ends, and to repeat the administration of outcome measures.

Format

The format of a typical session was as follows:

- To obtain feedback from the group about what had been working for them since the previous week.
- To have a group discussion around any particular concerns that group members raised, in order to help them achieve a satisfactory way forward. Facilitation encouraged participants to help one another to find solutions, as well as the provision of individual discussion
- To agree a home work task, based on their use of recovery tools which group members could put into practice by the next group meeting.

Group process

The group was facilitated by two people, a leader and an observer. The facilitation of the group adopted a semi-didactic style, yet encouraged interaction between group members in an attempt to draw out similar themes and hence to bring out universality of experience (Yalom, 1985). The experienced Clinical Psychologist took the lead in facilitating the group, and the trainee psychologist took the lead in scribing the content of the sessions, making a contribution to the discussions as appropriate.

The group members had met each other at some stage within the service, so were familiar to some degree with one another's individual narratives. The group was therefore partially formed at the start, and this seemed to ease their ability to self-disclose fairly quickly. All of them were interested to know more about the concept of recovery, although they were mixed in their view of whether recovery was possible. A persistent theme throughout the programme was the barriers to recovery that the group members had identified. A general consensus from the group was that their process of recovery was hampered by the side effects of medication, an ideology on non recovery after mental illness, a lack of social support from friends and family, a lack of activities and 'things to do', unemployment, lack of finances, dislike of their area of residence, and a feeling of vulnerability within the community. Their experiences were affirmed, and explained within the context of the traditional view of psychiatric care. It was suggested that hopefully in the future, attitudes will change as services become more recovery oriented in focus. A useful idea, that seemed to help individuals move beyond this cycle of hopelessness was to encourage them to begin to see the small signs of progress in their lives. Much work was needed to help people identify a reason to keep going, especially when they had been users of psychiatric services for many years.

Most of the group members found the video helpful. Much discussion of this centred around the fact that they felt they did not have a voice. Their experience in the group in this regard was quite unusual as they were encouraged to have a voice, which was listened to and taken seriously. They appeared to find the group cathartic (Yalom, 1985).

Throughout the programme, it had been noticed that the group members were more likely to interact with each other, offer suggestions and generally looked forward to the meetings. The majority of the group members reported finding the program helpful as it offered an opportunity to discuss new concepts with a professional as well as with each other. In addition, the participants felt that they benefited from receiving feedback and information about their own progress and various coping techniques that could be used outside of the group. Most of the group members wanted to continue with the group on an indefinite basis.

Evaluation of the group

The evaluation of whether the group was successful or not sought to take into account the perspectives of the group members, group facilitators and the work setting (Doel and Sawdon, 1999).

Group members

At the last meeting, group members were invited to reflect on their experiences of being in the group, and to identify what they found helpful and unhelpful about being in the group. Overall, they welcomed the model of recovery within mental health services, even though, in their daily lives they felt that they struggled to make this a reality. They felt that the discussions from the group helped them to challenge some of the negative thoughts that they struggled with about their lives, and some of the unhelpful encounters from others that they may have encountered.

Interestingly, one year after the recovery group, the following observations were made about the outcomes observable in the lives of the four participants of the group:

John who was an inpatient, was discharged to a group home. This was a big step for him, given that he had never lived away from home before. It was timely for him to make this move because his parents who were in their late seventies felt that he needed to start preparing for when they will not be around any more. With the help of his care co-ordinator, he also managed to get a job in a supermarket, and he volunteered to participate in a Cognitive Behavioural Treatment Trial which meant that he would receive one to one therapy for a period of six months. He welcomed this, because he had a number of issues that he wanted to work through.

Peter who was an inpatient, was discharged to a group home. He used to travel quite a bit before he became unwell, but had not done so in years. At the group home, he was able to inform his key worker about this aspiration, who sought to work with him to help him develop confidence to be able to do this. A start was made on this by inviting Peter, to go away with others at the group home for weekend trips. He is yet to go away independent of the group home.

Sam who was an inpatient was discharged from the inpatient unit into independent living accommodation and has managed to secure some voluntary work. He continued to experience mental health crises from

time to time, and on one occasion he rang CV to be seen on an individual basis to discuss his concerns. During this meeting, he disclosed some experiences of childhood trauma, which he has never been able to do before, and saw the flashbacks of these as a reason for why he feels he has not been able to move on in life. He did not feel ready to take up the offer of trauma focussed therapy, but at least disclosure of it was the beginning of moving towards recovery.

Mangit, who lived in the community during the group, had been discharged from having to take medication, following a mental health tribunal, and now lives in his own flat with his girlfriend. This was quite an achievement for him, because he disagreed for years with having to take medication, but was told that he must continue to take it to prevent a relapse. Apparently, the damaging effects of the medication, including reduced libido outweighed the benefits for him.

They may not have achieved their ultimate goals during this time (see table 1), but it is likely that they were making steps towards them.

The facilitators

One author was a trainee health psychologist who wanted to gain some experience within mental health services. She also wanted to use the group as one of her case studies, so was very keen to evaluate its effectiveness. Her needs fitted in very much with the needs of the setting. The other author was keen to develop groupworking within the service, and valued this commitment.

The setting

Part of the borough wide services was undergoing a reconfiguration from traditional day centres to a Therapeutic Intervention Service, which provides evidence based groupwork. The facilitators were keen to use outcome measures to demonstrate the efficacy of a model for groupworking with potential benefit for the patients, which would be adopted in the new service as a treatment option for patients. In addition, a review of the rehabilitation service had recommended that the rehabilitation service should become more recovery focussed, so the recovery group provided an example to other staff of how recovery focussed working practices could be implemented.

Table 1

Perceived goals for the future relative to current and two years previously (recorded verbatim)

<i>Client</i>	What was life like before you came into hospital?	What would improve your satisfaction with life?	What do you hope to be doing in two years from now?
<i>John</i>	Life was pretty bad before I came into hospital.	Going on a holiday and seeing my animals .	In two years time I hope to be well.
<i>Peter</i>	I had a bad time before going into hospital.	Going on holiday to Brighton and to see more of my family.	I hope to be in a hostel or residential home. To form a relationship.
<i>Sam</i>	I was anxious, worried and unhappy	To secure a job in psychiatric nursing.	To be working as a psychiatric nurse.
<i>Mangit</i>	Had a breakdown.	Making more friends, Finding a career in IT, studying German.	Hope to earn good money doing a job in project management.

Outcome measures

The outcome measures were used to assess for the original aims of the group which were as follows:

1. To help increase:
 - Their hopefulness about achieving their future aspirations.
 - Their motivation to pursue life goals.
 - Their motivation to improve their degree of quality of life.
2. To provide a supportive forum

The following measures were used before and after the intervention:

The Lancashire quality of life questionnaire –QoL (Oliver, 1992)

This is divided into 10 domains (General well-being, Work/Education, Leisure Participation, Religion, Finances, Living Situation, Legal and Safety, Family Relations, Social Relations, Health and Self-concept).

The Beck Hopelessness Scale – BHS (Beck, 1974)

This was used to measure levels of hopelessness. The norms for this scale are: Normal=3 Mild = 4-8; Moderate = 9-14; Severe = 14.

The Bradburn Scale (1969)

This was used to measure psychological well-being.

Cantril's Self-Anchoring Ladder (1967)

This was used to obtain the participants view of their current life, relative to life two years ago and how they hope life will be in two years time. A score of 10 represents a best possible life and a score of 0 represents a worst possible life.

Goal Focussed Exercise

This was developed by CV in order to find out from the participants what they ideally would hope to be doing with their lives in two years time, relative to what they were doing two years ago, and currently (see Table 1).

Outcome of intervention

Analysis will be based on the four participants who attended the full programme.

Quantitative changes

1. *Levels of hopelessness*
 - The overall mean results from the Beck Hopelessness Scale suggests that the participants levels of hopelessness remained within the mild range through out the intervention (see Table 2).
2. *Psychological well-being*
 - The overall mean results from the Bradburn Scale suggests that the participants overall well- being increased marginally from beginning to end of the intervention (see Table 2).

Table 2

Means scores of hopelessness (BHS), psychological well-being (PW) and life ladder scores.

N = 4	BHS ¹	PW ²	Life Ladder ³		
Pre group	6.5	5.25	present (5.25)	past (7.5)	future (9.25)
Post group	5.75	6.25	present (3.5)	past (6.75)	future (7)

1. *The Beck Hopelessness Scale* was interpreted in relation to any change in number of points referred to hopelessness from the inventory. The norms for this scale are: Normal=3 Mild = 4-8; Moderate = 9-14; Severe = 14.

2. *The Bradburn Scale* was calculated by every Yes response given 1 point and No response given 0 points. Positive affect items included 1,3,5,7 and 9. Negative affect items included 2,4,6,8 and 10. Psychological balance was calculated by the difference between positive affect and negative affect, and the addition of a constant of 5 (Scores can range from 0 to 10).

3. *The Life Ladder* provided ratings between 0 (worst possible life) to 10 (best possible life).

Table 3

Mean total satisfaction scores for quality of life domains

QoL Domains	Pre-group	Post group	Increase/Decrease
General well-being	3.5	3.25	Decrease(Same range)
Work/Education	2.25	2.75	Increase(Same range)
Leisure/Participation *	14.0	13.5	decrease
Religion *	7.5	7.0	decrease
Finances *	9.0	7.5	decrease
Living situation *	29.75	27.5	decrease
Legal and safety *	7.25	8.25	increase
Family relations *	10.5	10.0	decrease
Social Relations *	9.5	10.0	increase
Health *	12.5	11.75	decrease
Self concept	1.5	2.0	Increase(Increase range)

The Quality of life was measured on a Likert scale format from 1 (displeased), 2 (mostly dissatisfied), 3 (mixed feelings), 4 (mostly satisfied) to 5 (pleased).

*QoL domains were calculated by adding up the number of points for each descriptor.

3. *Quality of Life*

- Levels of satisfaction with General Well Being, Work/education, Self-concept: These results suggest a level of satisfaction , no greater than within the ‘mixed feelings’ range both before and after the group.
- General levels of quality of life reported in the following domains: Health, Finances, Living situations, family relations, social situations, and Health show a marginal decrease from beginning to end of the group. A marginal increase in levels of quality of life was shown for Legal and Safety aspects and Social relations. (Table 3)

4. *Anchoring Ladder Scores*

- These results show a decreased perception of how the past, present and future was seen after the intervention. They do show, however, that participants remain optimistic about improvements that they would like for their future life.

Qualitative Measures

1. *Goals for the future*

By the time the group had finished, all of the participants reported at least making enquiries to pursue their desired goals (see Table 1).

Discussion

The overall aim of the recovery group was to introduce service users to a recovery model of care, with the hope that the forum could yield the following outcomes:

- To increase people’s hope about pursuing their personal aspirations.
- Increase people’s awareness of a new service philosophy that has potential to be supportive.
- Support from other service users.
- Help people identify their inherent coping strategies.
- Help improve people’s quality of life.

Mixed findings were found in relation to measures of hopelessness, quality of life, psychological well-being and perceptions of themselves in the past, present and future. The outcome measures suggest some improvement in relation to increased levels of quality of life (in some domains), and increased psychological well being. Whilst the results showed lowered perceptions of how the past, present and future was seen after the intervention, participants remained optimistic about improvements that they would like for their future life. This result is consistent with the score on the Beck Hopelessness Scale, where the score remained within the mild range for hopelessness. The results from this evaluation could be explained in several different ways.

Firstly, in regards to the specific quantitative measures it could be argued that despite some improvements from the Recovery Group in comparing the baseline with after the intervention, the achievement of mixed results could be due to a bigger problem within the community as a whole and general aspects of the way services are delivered. For example, although the service users embraced the recovery model, the often had a different view from health professionals as to whether recovery from mental illness was actually possible. Thus supporting the previous studies of a permanent stigma of 'mental illness' (Ahern & Fisher, 1999; Davidson and Neale, 2001; Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002; Matorin, 2002; Perlick & Rosenheck, 2002 and Wahl, 2003). Self-fulfilling prophecy theory (Rosehlm and Jacobson, 1957) would suggest that if there is a strong enough belief outside a group that is negative then after time the service user may start to internalise the belief. As identified in previous research for example, (Fisher, 1998) this negative stigma was found on numerous occasions when a service user in the group wished to find employment within a voluntary or paid capacity. Furthermore, the service users reported other barriers to their recovery, such as the side effects of medication, a lack of finances, dislike of their living environment and a feeling of vulnerability within the community. The work of the National Institute for Mental Health in England (NIMHE), which aims to help support services become more recovery oriented may help towards a long term strategy of eventually eliminating such barriers.

Another issue concerns the effect of institutionalisation and learned helplessness on outcome. Davidson and Neale (2001) discuss that over a period of time a mental health service user could become so

reliant upon psychiatric services that they become accustomed to the negativity of others towards them, as well as accepting of an inability to do things for themselves. Studies have found that having access to something that a service user has ultimate control over such as a pet or a plant was shown to have significant improvements towards their health and quality of life (Gross, 1996). A challenge for services who seek to take the recovery agenda forward will therefore be to first undo the legacy of the past.

Furthermore, the gender of the clients may have influenced outcome. Firstly this group contained only males. Various research have found gender differences in reference to aftercare and psychiatric hospitalisation with adults experiencing mental illness (Klinkenberg and Calsyn, 1998) Similarly, DiNitto, Webb and Rubin (2002) found gender differences with dual diagnosis and mental illness whereby females were more concerned about their psychiatric symptoms and its effect on family and social relations. Indeed one service user in this study expressed concern about criticism and isolation from his family, which is consistent with previous research on male service users who were found to have an increased chance of receiving harsher family attitudes about their condition (Davis, Goldstein and Nuechterlenin, 1996).

Another area concerns the duration of the group programme. The recovery group took place over eight weeks, which may not have provided sufficient time for any observable change to occur. In fact, participants asked for a longer duration for the group. This could not be offered, however, because of the availability of the facilitators.

As highlighted earlier, improvements had been identified in the lives of the participants. John who was an inpatient, returned to live in his flat. He has a job in a supermarket. Peter who was an inpatient, was discharged to a group home, and is hoping to go on holiday with his mother. Sam who was an inpatient was discharged from the inpatient unit into independent living accommodation and has managed to secure some voluntary work. Mangit, who lived in the community during the group, has now been discharged from having to take medication, following a tribunal, and now lives in his own flat with his girlfriend. It would appear, that in spite of some of the barriers for change, these individuals have managed to make some improvements. It would be interesting to obtain follow-up information on these participant at least one year later, in order to identify whether their progress has been

maintained, and if so, whether they attribute this to the intervention of the group. The facilitators, however, have now lost touch with the group members.

One can only speculate as to whether it was actually what the participants received from the recovery group that made the difference to their recovery. The inclusion of a control group would control for confounding variables outside of the Recovery Group and one would be able to see whether the Recovery Group successfully affected the variance in relation to recovery (Coolican, 2000).

Furthermore it could be argued that with such a small sample of 4 service users this poses great limitations in offering generalisations for other services, and that the 8 week duration was highly limited for the extent of recovery which could differ from person to person (Murray, 1996). The group however, was found to have some benefit to the clients.

As the NHS is now outcome driven, the facilitators thought it prudent to use measures that could support the assessment of why the group was set up in the first place. The number of measures used could have been off putting for the group members, but it was indicated to them that this approach could help guide the intervention process. Unlike, other interventions, this information was actually shared with the group members, so that they could experience the usefulness of the measures in monitoring signs of any improvement that they may have made.

This case study provides an example of a way of working that can help support the recovery process of service users. Now that the recovery approach is government policy, the hope is that in the years to come, recovery for service users will become more of the norm than the exception.

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