The seven habits of recovery-oriented psychiatrists: a non-clinical guide for personal growth and development

Arun Jha,[1] Mithilesh Jha[2]

The Psychiatrist (2012), **36**, 345–348, doi: 10.1192/pb.bp.111.037473

[1]Hertfordshire Partnership NHS Foundation Trust; [2]Lincolnshire Partnership NHS Foundation Trust

Correspondence to Arun Jha (arun.jha@hertspartsft.nhs.uk)

First received 1 Nov 2011, final revision 15 Dec 2011, accepted 2 Mar 2012

Summary British mental health trusts are trying to organise and deliver services based on recovery principles. Psychiatrists are perceived to be either reluctant or opposed to adopting these principles, although there is some support for recovery-oriented practice. In this paper we highlight the recovery needs of psychiatrists and propose a framework of internalising recovery principles in order to develop recovery-conducive habits based on Stephen Covey's popular book *The 7 Habits of Highly Effective People*.

Declaration of interest None.

There is a national drive in the UK to ensure that services are organised and delivered in line with recovery principles.[1,2] The new mental health strategy for England *No Health Without Mental Health*[3] reiterates recovery principles by putting the patient at its centre, with shared decision-making, choice and information. The challenge for psychiatrists is to look beyond clinical recovery and to address the personal recovery needs of patients in order to assist them to get on with life according to their hopes and aspirations. A recent position statement by psychiatrists[4] provides a conceptual and practical framework to turn the vision of recovery into reality. We believe that psychiatrists need to personally develop before being able to help others recover. In this paper we discuss current recovery ideas and steps taken to implement them, and propose a framework of internalising recovery principles in order to develop recovery-conducive habits.

Recovery ideas and practice

The English mental health service is one of the most structured services in the world and it provides a range of very good services. But there is a general perception that the traditional mental health service is predominantly medical in design, biological in principle and outcome-driven in practice. The concept of recovery came into psychiatry as a set of ideas of self-determination and self-management, which emphasise the importance of hope in sustaining motivation and supporting expectations of an individually fulfilled life.[1] Since the beginning of its gradual introduction in Scotland in 2006 and in England in 2007, attempts are being made to convert these recovery ideas into practice.

Although the vision of recovery has generated considerable enthusiasm, introducing recovery into clinical practice is proving somewhat challenging. There is some support for recovery-oriented practice by psychiatrists as reflected by the findings of a preliminary survey carried out by the first author (A.J., details available on request) in mid-2011 in Hertfordshire to find out about psychiatrists' knowledge, skills and attitudes towards recovery. Although, out of 150 psychiatrists only 33 returned the completed questionnaire, the majority believed that a recovery approach is very useful in psychiatry, and that they already have sufficient knowledge and skill to practice it. Open comments included, 'Limited use in severely mentally ill patients'; 'Recovery is a journey made by patients, helped by professionals'; 'It has been used for many decades in learning disability psychiatry but wasn't given an official title'; 'Recovery is a jargon'. These statements reflect the currently held diverse views about recovery by psychiatrists in different subspecialties.

Token recovery practices and superficial engagement such as being kinder to people but not changing practice, dismissing patients on the basis that they need to help themselves more or asking service users to write life stories but not reflecting them in their care plans, are common pitfalls in the recovery-focused approach. Some services and practitioners have indeed seen merit in superficially relabelling themselves as 'recovery-oriented' without engaging with the fundamental changes. Psychiatrists are still grappling with the challenge of how to inculcate recovery principles in their clinical practice because the concept of recovery appears vague and there is scepticism about the various tenets of recovery. Recovery-oriented psychiatrists do not necessarily have to be saints, as they can develop a recovery approach in their clinical practice by remaining aware of their strengths and shortcomings. Recovery highlights common humanity. It is all about growth, and unless psychiatrists understand the real meaning of growth, and start working for their own personal growth, they may find it difficult to practice recovery. They need to go beyond the medical model of diagnosis and

treatment. There has to be a fundamental change in the day-to-day interaction between clinicians and service users.[5] There is enough literature on the desired attributes of a recovery-oriented professional, but not much is available to promote personal growth of psychiatrists. A Norwegian qualitative study[6] found that service users valued professionals who conveyed hope, share power, were available when needed, were open regarding diversity in what helps, and those who had the courage to deal with the complexities and the individuality of the change process. Similar attempts to define the competencies and skills of recovery-oriented practitioners have been made by others.[1]

Rethink, a leading British mental health charity, has produced a series of documents about recovery ideas. Its fourth volume, the Refocus manual,[7] describes an intervention aimed at increasing the focus of community adult mental health teams on supporting personal recovery. The intervention identifies the intended effects of the intervention – the 'practice change', i.e. the impact the intervention has on the team and staff, and the impact on the experience of the person using the service. In the Refocus trial, six strategies have been used to implement the intervention. 'Personal recovery training' is one of those strategies relevant to this paper. During one of the three half-day training sessions, team members are encouraged to increase self-awareness about the impact of their personal and professional values, beliefs, working practices, routines and boundaries. Although the effectiveness of that training remains to be evaluated, such opportunities are limited and not available to trainee and substantive psychiatrists. Similarly, the Sainsbury Centre for Mental Health's ten top recovery-oriented reflective practices[1] includes the skill of active listening, an attitude of respect, etc. These top tips are presented as principles, to be translated into a set of standards for teams. This has certainly provided managers with a person specification for staff recruitment and a structure to feedback to staff on their performance, but we are unsure whether these initiatives have enhanced psychiatrists' recovery skills and practices.

From their American experience, Davidson and colleagues[8] provide a valuable framework for enthusiastic readers. They suggest a recovery guide model of practice as an alternative to clinical case management and tools to self-assess the recovery orientation of practices and practitioners. In doing so, they go beyond the rhetoric of recovery to its implementation in everyday practice. However, the enormity of standards and core principles may prove daunting to teams to understand, learn and implement. Moreover, it lacks a road map for accomplishing these goals.

In 2011, the *Journal of Mental Health Training, Education and Practice* dedicated its entire sixth volume to the current recovery climate in the UK. Although none of its papers contain evaluative data of outcome, Roberts and colleagues[9] have proposed some very practical recovery-promoting steps. From their experiments with 'recovery awareness courses' for willing applicants they have identified four distinctive attributes including awareness, understanding, skills and qualities, and 'the person of the practitioner'. The authors, however, confess that their training has so far had far more of an impact within the third sector and with independent providers than within their Devon Partnership National Health Service (NHS) Trust.

In the past few years the recovery directorate of Hertfordshire Partnership NHS Foundation Trust has been working very closely with the Sainsbury Centre for Mental Health, and has managed to inspire a significant number of staff in thinking about recovery. To propagate the recovery momentum to our psychiatrist colleagues, some of the recovery-minded psychiatrists have formed a recovery implementation group. Currently, the group is exploring ways and means of developing in-house recovery training programmes specifically for the medical workforce. Similar initiatives are being undertaken in Lincolnshire and other trusts. The next two sections of this paper present some of our experiences and observations, explore new recovery ideas and propose a framework for promoting personal growth in the recovery context.

Recovery-oriented practice as a core competency

Most human behaviour is done habitually. Habits are a pattern of thoughts, feelings or behaviours that, through the process of repetition, have largely become unconscious in the life of the individual.[10] As physicians, we develop the habit of diagnosing patients by using the traditional steps of history-taking and a mental state examination. The Royal College of Psychiatrists' new competency-based curriculum is also based on the traditional model of diagnosis and management.[11] The bulk of core competencies include knowledge of common psychiatric disorders and their treatment. However, one of its 18 'intended learning outcomes' is to demonstrate 'respect, empathy, responsiveness, and concerns for patients, their problems and personal characteristics'. This goes to the heart of the recovery approach. Whether our current trainees receive appropriate recovery-oriented clinical exposure remains open to debate.

Psychiatrists are expected to demonstrate knowledge of how to structure the clinical interview to identify patients' concerns and priorities, their expectations and their understanding by soliciting and acknowledging expression of their ideas, concerns, questions and feelings. In our view this aspect of psychiatric consultation is not given adequate consideration. We often conclude a typical psychiatric interview by saying 'I've asked you a lot of questions; is there anything you would like to ask me?' This does help patients express some of their expectations, but does not lead to the patients' inner world. Similarly, obtaining the trust of patients is the doctor's most important goal. The key to developing trust is the demonstration of empathy. Modern NHS psychiatrists face criticisms of two kinds – not showing enough empathy during assessment and relying heavily on pharmacological treatments.

Eliciting idiographic knowledge – understanding of subjective phenomena – is an important clinical skill.[12] Recovery-oriented psychiatrists continue practising the most fundamental element of descriptive psychopathology – the 'empathic assessment of subjective experience' of the patient.[13] In our view, this approach is broader than the idiographic approach. In order to maintain our professional

https://doi.org/10.1192/pb.bp.111.037473 Published online by Cambridge University Press

stature, trainee psychiatrists need more hands-on training and supervision in learning empathic assessment techniques. Clinical supervisors should endeavour to demonstrate to their trainees the outcome of the empathic assessment with the subjective needs of the patient. If we continue diagnosing and treating illnesses without addressing the personal recovery needs of patients, we are at a risk of being marginalised and undermined.

As is the case in psychotherapy training, practising psychiatrists and other mental health professionals need personal training in their own personal growth and fulfilment before attempting to join their patient's recovery journey. The recovery ideas and principles need to be practised in day-to-day life. When the principles are internalised into habits, argues Covey,[14] they empower practitioners to create a wide variety of practices to deal with different individuals. Our paper, inspired by Covey's *The 7 Habits of Highly Effective People*,[14] provides a framework of internalising recovery principles in order to develop recovery-conducive habits.

The seven habits of recovery-oriented psychiatrists

Roberts and colleagues[9] believe that 'you can only start from where you are and you will inevitably start with those who have a spark of interest and enthusiasm'. How can we generate that spark?

Recovery training and learning new recovery techniques may change our outward attitude and behaviour, but the spark does not flash unless we change the basic paradigms from which those attitudes and behaviour flow. We need a deeper level of thinking based on the fundamental principles of life related to fairness, integrity and honesty, human dignity and quality or excellence. According to Covey:[14]

> Principles are not practices. A practice is a specific activity or action that works in one circumstance but does not necessarily work in another. While practices are situationally specific, principles are deep, fundamental truths that have universal application. Principles are guidelines for human conduct that are proven to have enduring, permanent value. When these truths are internalised into habits, they empower people to create a wide variety of practices to deal with different situations.

He defines a habit as: 'the intersection of knowledge, skill and desire. While knowledge is the theoretical paradigm, the "what and why to do", skill is the "how to do", and desire is the motivation, the "want to do". In order to make something a habit in our lives, we have to have all these three elements'.

We may be ineffective in our interactions with patients if we constantly tell them what we think, and never really listen to them. Even if we know that in order to interact effectively with others we really need to listen to them, we may not have the skill. Even knowing we need to listen and knowing how to listen is not enough. Unless we want to listen, unless we have the desire, it will not be a habit in our life. Creating a habit requires work in all three dimensions. By working on knowledge, skill and desire, we can break through to new levels of personal and interpersonal effectiveness. It is a change that has to be motivated by a higher purpose. One may call it just good clinical practice or spirituality, but this is the beginning of the transformation from being an average clinician to a recovery practitioner.

The seven habits of highly effective people are also applicable to recovery-oriented clinicians. In harmony with the natural laws of growth, these habits provide an incremental, sequential, highly integrated approach to the development of personal and interpersonal effectiveness. They move us progressively on a maturity continuum from dependence to independence to interdependence. Dependent people need others to get what they want. Independent people can get what they want through their own effort. Interdependent people combine their own efforts with the efforts of others to achieve their greatest success.

During our psychiatric training, we grow from being a dependent trainee to an independent consultant, and keep learning to be interdependent with various multidisciplinary teams. However, most of us remain stuck at the level of independence, and only a few become truly interdependent. Our annual appraisal process and continuing professional development activities are geared towards making us independent. They make us good individual clinicians, but not effective leaders or team players. More effort should be devoted to team working and interdependent skills than to individual knowledge. To achieve that ultimate goal, Covey's seven habits of effective people may be helpful.[14] The recovery-oriented habits based on Covey's framework are outlined in Table 1.

The first three habits deal with self-mastery. They move a person from dependence to interdependence – the essence

Table 1 The seven habits of recovery-oriented psychiatrists

Effectiveness habits	Description	Recovery-oriented habits
1 Be proactive	Principles of personal vision	Self-awareness
2 Begin with the end in mind	Principles of personal leadership	Creating your own style
3 Put first things first	Principles of personal management	Stick to your values not to your instincts
4 Think win/win	Principles of interpersonal leadership	Team working
5 Seek first to understand, then to be understood	Principles of empathetic communication	Empathic listening
6 Synergise	Principles of creative cooperation	Value differences
7 Sharpen the saw	Principles of balanced self-renewal	Continuous personal and professional development

Adapted from Covey.[14]

https://doi.org/10.1192/pb.bp.111.037473 Published online by Cambridge University Press

of character growth. Interdependence is a choice only independent people can make. As we become truly independent, we have the foundation for effective interdependence. You have the character base from which we can effectively work on the more personality-oriented teamwork, cooperation and communication found in habits four, five and six. Habit seven is the habit of renewal. It is the habit of continuous improvement that creates the upward spiral of growth that lifts us to new levels of understanding and living each of the habits as we come around to them on a progressively higher plane. The effectiveness of the entire approach is more than the sum of these habits.

We also believe that the most enduring changes come from shifts at a deeper level as a result of diligently practising specific skills and techniques, learning the principles of recovery. These seven habits are not equivalent to recovery attributes, but they would certainly enhance the clinician's personal growth and help them become a more effective recovery-oriented practitioner. Once 'recovered', they can become the anchor points, champions, enthusiasts and leaders who 'get it', for 'recovery' is not an agenda that can be easily parachuted in or successfully imposed.[9]

Conclusions

Psychiatric practice is becoming more and more recovery-oriented. Psychiatrists are expected to adopt a recovery approach to practice. Various models are available for becoming a recovery practitioner. This paper outlines one such model to help psychiatrists, especially those willing to be a convert, internalise the principles of recovery, put them into practice and make them a habit. In order for psychiatrists to be recovery-oriented, they need to develop themselves personally, for recovery is the fruit of psychiatrists having interdependent skills. In the process of helping patients live a satisfying, hopeful and contributing life, psychiatrist colleagues will experience satisfaction, hope and contributing to the NHS despite feeling frustrated at times.

Acknowledgements

We would like to thank members of the Hertfordshire Mental Health Recovery Implementation group (Anne Markwick, Sadgun Bhandari, Chris Hawley, Alexis Bowers, Kamalika Mukherji, Billy Boland and Lisa Mukherjee) for their contribution in the questionnaire survey and subsequent recovery-related lively discussions.

About the authors

Arun Jha is a consultant in old age psychiatrist, Hertfordshire Partnership NHS Foundation Trust. **Mithilesh Jha** is a consultant in general adult psychiatry, Pilgrim Hospital, Boston, Lincolnshire.

References

1 Shepherd G, Boardman J, Slade M. *Making Recovery a Reality*. Sainsbury Centre for Mental Health, 2008.

2 Sainsbury Centre for Mental Health. *Implementing Recovery. A New Framework for Organisational Change. Position Paper.* Sainsbury Centre for Mental Health, 2009.

3 HM Government. *No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of all Ages.* Department of Health, 2011.

4 South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust. *Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists.* SLAM/SWLSTG, 2010.

5 Roberts G, Wolfson P. The rediscovery of recovery: open to all. *Adv Psychiatr Treat* 2004; **10**: 37–48.

6 Borg M, Kristiansen K. Recovery-orientated professionals: helping relationships in mental health services. *J Ment Health* 2004; **13**: 493–505.

7 Bird V, Leamy M, Le Boutillier C, Williams J, Slade M. *Refocus: Promoting Recovery in Community Mental Health Services.* Rethink, 2011.

8 Davidson L, Rowe M, Tondora J, O'Connell M, Staehell Lawless M. Practice standards for recovery-oriented care. In *A Practical Guide to Recovery-Oriented Practice: Tools for Transferring Mental Health Care* (eds L Davidson, M Rowe, J Tondora, M O'Connell, M Staeheli Lawless): 89–149. Oxford University Press, 2009.

9 Roberts G, Good J, Wooldridge J, Baker E. Step towards 'putting recovery at the heart of all we do': workforce development and the contribution of 'lived experience'. *J Ment Health Train, Educ Pract* 2011; **6**: 17–28.

10 Roychowdhury A. Bridging the gap between risk and recovery: a human needs approach. *Psychiatrist* 2011; **35**: 68–73.

11 Royal College of Psychiatrists. *A Competency Based Curriculum for Specialist Training in Psychiatry.* Royal College of Psychiatrists, 2009.

12 Slade M. Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Serv Res* 2010; **10**: 26.

13 Sims A. *Symptoms in the Mind: An Introduction to Descriptive Psychopathology (3rd edn).* Saunders, 2003.

14 Covey SR. *The 7 Habits of Highly Effective People.* Simon & Schuster, 2004.

https://doi.org/10.1192/pb.bp.111.037473 Published online by Cambridge University Press