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ORIGINAL PAPER

Recovery from Mental Illness: A Service User Perspective on Facilitators and Barriers

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Abstract Mental health services strive to implement a recovery-oriented approach to rehabilitation. Little is known about service users' perception of the recovery approach. The aim is to explore the service user's perspectives on facilitators and barriers associated with recovery. Twelve residents living in supported housing services are interviewed. The analysis is guided by a phenomenological-hermeneutic approach and the interpretation involves theories from critical theory, sociology, and learning. Learning, social relations, and willpower are identified as having an impact on recovery. Stigmatization and social barriers occurred. Social relations to peer residents and staff were reported as potentially having a positive and negative impact on recovery. Studies have explored the user's perspectives on recovery but this study contributes with knowledge on how recovery-oriented services have an impact on recovery.

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Introduction

Mental health recovery is a worldwide vision and a goal in social policy, in mental health research and in psychosocial rehabilitation (Shulamit et al. 2007; Eplov et al. 2010; Wilken and Hollander 2008; Slade 2009). Recovery-oriented mental health rehabilitation is described as the guiding principle in system reforms and should be available to everyone with a mental illness (Lancet Global Mental Health Group 2007). For the past decade, Danish municipalities have implemented supported housing options with a recovery-oriented approach to rehabilitation. Mental illness is no longer perceived as a chronic illness, but as a condition from which one can recover (Wilken 2007; Topor 2005). This calls for a major shift in the service delivery from managed, maintenance-oriented care to self-directed care (Glover 2005).

People with a mental illness, even those diagnosed with severe mental illness, recover (Calabrese and Corrigan 2005) when the term recovery is defined as "finding new meaning and purpose in life" (Anthony 1993). Such a broad and inclusive definition of recovery is likely to be relevant for service users' situations. Several factors have been identified as factors that facilitate recovery, including hope and social relations (Hydén 1995; Topor et al. 2009; Schön et al. 2009). In order to advance recovery from mental illness, such facilitating factors must be encompassed by the particular strategies mental health services use (Jacobsen and Greenley 2001; Slade et al. 2008).

Models of organizational change towards recovery-oriented services have been developed (Farkas et al. 2005,

2008; Wilken and Hollander 2008; Salyers and Stultz 2007). These recovery-oriented services set up partnerships, emphasize choice, instill hope (Salyers and Stultz 2007; Farkas et al. 2005, 2008), anticipate autonomy and empowerment (Spaniol et al. 2002; Davidson 2003; Deegan 2002), and they generate a culture of healing characterized by tolerance, empathy, respect, trust, and diversity (Jacobsen and Greenley 2001). However, various barriers appear to inhibit recovery from mental illness (Mezzina et al. 2006; Happel 2008). These barriers include, among others, organizational barriers which can inhibit the intended outcome of empowerment (Townsend 1998). Limited knowledge exists on service users' perspectives on these recovery-oriented services. The aim of the present study is to explore the service user's perspective on recovery, the experienced facilitators and barriers associated with recovery and the contribution of recovery-oriented mental health services.

Methods

Individual, semi-structured interviews were deemed appropriate to explore and gain a deeper understanding of the service users' perspectives on facilitators and barriers associated with the process of recovery. The method of semi-structured interview allowed us to ask structured questions as well as open-ended questions about service users' individual recovery experiences. The qualitative study was guided by a phenomenological- and hermeneutic approach. The phenomenological approach gave the service users a voice and ensured a detailed presentation of their perspectives. The hermeneutic approach allowed us to interpret the service user's perspectives on recovery by involving theories that helped underpin the understanding of identified factors of importance for obtaining recovery. The data collection followed the methodological principles for designing and performing semi-structured interviews, as outlined by Brinkman and Kvale (2009). The analysis was divided into two phases: (1) Giorgi's phenomenological method of text analysis (Giorgi 2009), to safeguard the voice of the service users and (2) a hermeneutic interpretation using relevant theories (Brinkman and Kvale 2009), to qualify our understanding of the service user's perspective on recovery, the experienced facilitators and barriers associated with recovery and the contribution of recovery-oriented mental health services.

Inclusion Criteria

Included in the study were service users living in supported housing services aged 18–60, both genders with a minimum of 1 year's stay. We also included service users who were about to end their stay, and who had more than 5 years' illness experience suffering from serious mental illness (schizophrenia and bipolar disorder).

Table 1 Study participants

Gender	Age	Duration of stay	Number of interviews
F	21	1.5 years	2
F	27	1.5 years	2
F	31	5 years	2
F	44	4 years	2
F	47	10 months	2
F	57	10 months	2
M	23	2 years	2
M	29	6 months	2
M	32	1 year	2
M	34	10 months	1
M	37	1 year	2
M	43	6 months	1

M male, *F* female

Exclusion Criteria

We excluded service users with delusions, difficulties in having a conversation, and service users living in mental health services with <5 years' experience of implementing a recovery-oriented approach to services.

Participants

Our sample consisted of 12 service users who had been living in three different supported housing services for between 6 months and 5 years. The sample included 6 women and 6 men aged 21–57 with a mean age of 35 (Table 1).

Setting

The setting of this study includes three supported housing services in a Danish municipality practicing recovery-oriented rehabilitation for the past 5 years. The vision of mental health services in Denmark, and in the supported housing services in the municipality are aiming at facilitating recovery. The essential value of the supported housing services is highlighted as person-centred, focusing on user involvement, self-determination and hope, and supporting each person in his/her individual recovery process. The supporting housing services in the municipality have been implementing a recovery oriented approach to rehabilitation with reference to the CARE model developed by Wilken and Hollander in Holland and recovery oriented mental health services developed by William Anthony and his staff at Boston University.

An average stay lasts 2–3 years, sometimes longer. Mental health services in the municipality encompass outreach work, day-care services, special education, and home support. Approximately 15–20 people live in each unit, in two-room apartments with a bathroom and a kitchenette. Staff works 37 h per week, and they are recruited from a range of professional backgrounds: social workers, social- and health care assistants, nurses, and occupational therapists. Staff helps residents with the preparation of meals, laundry, cleaning, arranging trips and social activities. The main entrances to the apartments open into shared corridors, where common rooms are available for watching TV and cooking meals.

Data Collection

Semi-structured interviews were carried out by three members of the research team [Petersen, Andersen and Wind]. Twelve service users participated in the study, ten service users were interviewed twice within 1–2 weeks in order to elicit a deeper understanding of their perspectives on recovery and two service users were only interviewed once. Each interview lasted between 20 min and 2 h, giving us 15 h of audio-recorded interviews in total. Recovery factors identified in a literature review on recovery from mental illness (service delivered, help from providers, support from others, living conditions, work, education, budgeting, motivation, personal resources, will power, hope, spirituality, and turning points) were used to structure the interview guide. Each individual interview was related to the service user's own personal perception of recovery, possible influence of internal and external factors, and experienced facilitators and barriers to recovery while living in supporting housing services. In the first interview, open-ended questions and follow-up questions were used. In the second interview, specifying, direct, and interpreting questions were used (Brinkmann and Kvale 2009). The second interview was a continuation of the first interview, and questions were based on our analysis of the first interview and sought to obtain a deeper understanding of the recovery process and experienced facilitators and barriers.

Data Analysis

Audio taped interviews were transcribed verbatim with names and places omitted. The texts were analysed employing Amedeo Giorgi's descriptive phenomenological method of text analysis (Giorgi 2009), followed by a hermeneutic interpretation (Brinkmann and Kvale 2009). The phenomenological analysis was chosen as to give an overall impression of the lived experiences of recovery. Giorgi's phenomenological method has been used in many dissertations and published in research articles. According to the method meaning units were identified and subsequently coded and condensed into themes and then related to each other (Malterud 2003). Service user's experiences on recovery were condensed into three major themes and related subthemes (Table 2). The research team undertook the analytic process in collaboration. Identified themes were analysed, and related to the whole text until an adequate interpretation evolved covering the participants' perspectives (Brinkmann and Kvale 2009). Interpretations were discussed to ensure that they were grounded in the participants' lived experience as expressed in the interviews. Investigator triangulation helped to ascertain the validity and durability of findings (Flick 2009). Four senior researchers and experts in recovery oriented rehabilitation formed a panel for an audit where the research team presented the preliminary findings. The purpose of the audit was to obtain a critical response on the identified themes and their interpretation. Findings were discussed including the validity of the identified themes of importance in the participant's perspective on recovery and the contribution of services.

Frame of Reference

A theoretical frame of reference involving theories on social practice (Dreier 1999; Dreier 2009; Wenger 1998a, b), situated learning (Lave and Wenger 1991), and stigma (Goffman 1963) were adopted after themes and subthemes derived from the phenomenological analysis. The theoretical frame of reference aided the interpretation of the participants' recovery experience and the impact supported housing services seems to have had on their process of recovery. Concepts from sociology and learning theory led to new ways of understanding the participants' perspective on recovery and the impact services in their perspective have had.

Ethical Considerations

In accordance with the Ethical Principle of the World Medical Association Declaration of Helsinki, full confidentiality was obtained and anonymity assured. Oral and written information about the purpose of the study and the contents of the questions was reviewed with the participants before the interviews. All participants signed a written, informed consent form, and they were informed that they could withdraw from the study at any time without any ensuing consequences. The study was reported to the Danish Data Protection Agency, journal no. 2010-41-4723, and to the Local Ethics Committee on April 24th, 2010. There is no known conflict of interest.

Table 2 Identified themes and subthemes in the service user perspective on recovery

Themes	Subthemes	Meaning units
Theme 1: learning		
Practical skills	Daily activities	"…yet you have made it through the first year…then it gets easier and easier" (to learn daily activities)
	Feeling valued	"…it is not difficult all the time … you get some experience … and fight the battle, and do something about it"
	Part of a group	"…it gives you this feeling of giving something back when you participate actively in the household"
Social skills	Meeting people	"…you learn a lot about yourself and how you can work on things" (when living with others)
	Creating long-lasting relations	"I have had a really good girlfriend while I have been living here"
	Education and work	"I have been in and out of hospital for the past 8–10 years so I have not been able to work" (have to learn social skills to be able to participate in work)
Ways to recover	Being in recovery	"…this spring, I thought I could see a noticable recovery…but…maybe it will just go bad again in the autumn"
	Coping with voices	"…it takes years to learn, I am on my way to learning some of it and I train [to cope with voices]"
	Hard work	"…they don't leave it all up to yourself, but they follow up… I feel like I might as well talk about what happens"
		"…you can see that you are succeeding and get satisfaction, then it gets easier"
Theme 2: social relations		
Relations in general	Poor social network	"I know that I am not alone and this is enough for me to prevent being psychotic"
	Difficulties in social relations	"..at night if I am awake and can't sleep, then I know that if I need to, if it gets worse, then I can call the staff"
	Being alone/needing others	"…in this way it becomes less and less necessary for me to contact them"
Staff	Close relations	"…you start to view the staff as friends…you know very well that it is a professional relationship"
	Continuity and trust	"…in a way, the staff are a sort of family to me"
	Support	"…if you get too bad, they knock on the door, then you come back to life and reality"
	Conversations	"…they talk to me and say…try and say what you really mean"
	Acceptance and recognition	"…it is nice to be able to speak freely… they know how, and understand how you think, then I understand I am not the only one in the world that feels like this"
Peers	Important relationships	"I have some real good girlfriends here […] if I didn't have them, I wouldn't have anyone"
	Sharing daily experiences	"I can go down and ask if anyone has some spare time they can spend with me"
	Understanding and acceptance	"…we understand each other better…you feel safe …you develop yourself with people who also have a mental illness"
	Shared illness experiences	"…you can tell the others, today I hear voices and we can support each other in getting better…we understand each other"
	Abuse	"…three times I have been abused by one of the residents living here, really bad rape and sexual abuse, it has been really difficult for me"
Relations to family	Poor family relations	"I have very little contact with my family"
	Feeling close	"having contact with my sister makes me feel close to the family"
	Acceptance and confidence	"…my mother should not be my therapist… she is my family and should be considered as my mother, so is my father"
	Belonging	
	Family not providers	
Relations to friends	Lack of friends	"I have never really had any friends, and if I have it has only been one, and then I got sick with an illness no-one understands"
	Shallow friendships	"I feel I am at the bottom of society…I am not important to anyone"
	Lack of girlfriend/boyfriend	"none of us residents have a girlfriend or boyfriend, you have to live alone with your illness"
	Longing for contact with people	"I would like to have contact with people outside the system"

Table 2 continued

Themes	Subthemes	Meaning units
Theme 3: willpower		
Making a choice	Motivation	"…it was my own decision so it is this motivation, you have to have it yourself…"
	Development	"you have to develop yourself"
	Independent	"I thought I might once in a while go into the fight, and develop myself … you might as well start now, the faster you do it the shorter time you have to be here and then you might be able to be more independent and live somewhere else"
Turning points	Breaking up	"…it has been a great change in my life, when I didn't tell my friends where I went, I did not tell them my new phone number"
	Ready for change	
	Time and energy	"I don't think you ever get finished… you cannot say now I am completely recovered…you have to get closer and closer, it is an essential part of it [recovery]"
Fighting	Struggle	"I have been fighting like a madman, I have sent the demons on the run"
	Activities as diversion	"sometimes I feel it is okay to manage it myself… I put some music on and draw, other times I can go down and ask if anyone has time to do something with me, watch TV or do other things just for half an hour or so…it is enough to avert the situation"
Uncertainty and doubt	Doubt	"…sometimes I believe it will go away [the illness], but deep in my heart I don't really believe it"
	Bad times	
	Losing faith	"…once you feel well, you can be afraid of getting ill again, which means you really get ill"
Faith and hope	Believing and hoping	"I definitely believe I can learn to live with it [the illness]"
	Seeking help	"I need help from others"
	Faith	"…it is a little wish to gain one's old life back"

Results

The study aimed to explore the service user's perspectives on recovery and their experiences on facilitators and barriers to recovery while living in recovery oriented mental health services. According to the service users, several interacting factors help facilitate recovery, but at the same time, several barriers inhibit the process. Firstly an introduction to the service user's overall perspectives on recovery and rehabilitation are presented. Secondly, the main themes derived from the phenomenological analysis are described (Table 2), followed by a hermeneutic interpretation of the identified findings. The phrases used by service users are kept in order to be true to their way of expressing their recovery experience. Three main themes in the service users perspective on facilitators and barriers to recovery are identified: (1) learning, (2) social relations, and (3) willpower.

The Overall Perspectives on Recovery and Rehabilitation

From the perspective of the service users, rehabilitation in the supported housing services is viewed as an individual learning process. The goal for the person undergoing rehabilitation is to develop skills and make changes in life. Rehabilitation is about developing one's own space for action, so that it is possible to move and live a normal life in the community: "… the reason for living here is because I need to learn things, about my illness and about having a normal life, cleaning, and making food …". None of the service users had a place of their own outside the supported housing; they all had to find suitable accommodation at the end of their stay. Participants view the supported housing services as a home: "Most of the time, I can easily be on my own from 10 pm to 7 am. It is like a normal home […], it is almost like this is my home and not an institution". Rehabilitation is experienced as a natural part of everyday life while living in the supported housing services; yet, life is also viewed as very different from ordinary life "outside". Participants view their stay as temporary and as having a particular purpose. Living with others and being surrounded by staff generates a situation they describe as being under constant supervision: "Staff gives you feedback on what you do…sometimes it can be a little hard because you feel that you are being assessed …you have to develop yourself while you live here". Participants distinguish between "the inside" and "the outside" world, and find it difficult to relate to people outside, from their perspective, they find it difficult to establish and maintain social networks outside. Residents are expected to follow the house rules and to participate in everyday activities,

e.g. cooking, cleaning, and socializing with other residents and staff. Engagement in work, education, and social life "outside" is sparse. As expressed by one of the service users: "I have never really had any friends […] I have an illness that many don't understand, or do not want to understand". When asked about the concept of recovery, service users points out: "It is all about getting better". Several service users had experienced turning points in their recovery process; it was described as changing points where big changes occurred. Recovery is seen both as an outcome and a process: "Recovery is a process where you work on getting better and learn to live with your illness". To some, recovery is similar to cure, and others view it as a learning process—learning how to take control of the illness. A successful recovery process is seen as depending on one's own effort but also supported by others. Everyone is aware of recovery as a vision for the services in which they live: "They use it [recovery] a lot here". Recovery is viewed by service users as the main goal in their rehabilitation.

Learning

The service users describe how several interacting factors facilitate the process of recovery. A stay in supported housing services plays a key role in learning how to recover. Learning, in the service users' perspective, is a pivotal factor in attaining recovery; learning involves practical and social skills, and being able to make changes in one's life and learn how to recover. The service users find that they have to work hard to learn new skills and strategies in order to recover. The goal of living in the supported housing services is to get better so they can move to a place of their own. The learning process is viewed as hard and demanding, but also as beneficial when proper support from staff is received. Due to years of mental illness and institutionalization, many of the service users say they have to learn practical, financial, and social skills from scratch. The service users feel dependent on help and support from staff during their learning process. The staff motivates and helps service users in solving everyday difficulties. Living with others is viewed by the service users as both positive and troublesome. Some enjoy the benefits of living in a kind of community with others and they learn from this. Others are proud to help out with day-to-day tasks: "…it gives you this feeling of giving something back when you participate actively in the household". Yet some feel group meetings held on how to perform daily activities are meaningless: "I don't want to hear the way people talk at group meetings, and they ask what do you think […] to me these meetings are meaningless". In the service users perspective learning how to recover is essential.

Social Relations

During the process of recovery, the service users are dependent on receiving help and support from others, from family and friends, staff, and peers. Being close to other people is seen as having a positive impact on recovery and as preventing psychotic episodes: "I know that I am not alone and this is enough for me to prevent being psychotic". Yet, the primary social relations are members of staff. Several of the service users cannot imagine living without the presence of the staff. Staff and peer residents are described as their friends and their family: "In a way, staff is a sort of family to me". As one expressed it: "I have some really good girlfriends here […] if I didn't have them, I wouldn't have anything". On the other hand some service users find it troublesome to live with other peers, as expressed by a woman: "I get worse when I socialize with residents that are ill". She hides in her room when too much attention is on mental illness. She find it difficult to live with people suffering from mental illness: "…it is all about mental illness: you go to school with people with mental illness, you live with people with mental illness, you party with people with mental illness, you attend festivals with people with mental illness…".

Few of the service users socialize with people outside the supported housing services and do not take part in social activities in the community. Overall, the service users reports having limited access to take part in a social network outside the services, keeping a job or taking an education. Many service users find it difficult to establish and keep contact with people and have limited contact with their family although they view it as being important. Once in a while, they need to be on their own but social relations are important in supporting recovery. Some have a close relationship with members of staff, especially with the staff they had known for a long time. Talking with staff is important and so is getting feedback on emotions and advice on how to socialize and solve conflicts. Some found relationships with other residents beneficial: "… I can go down and ask if anyone has some spare time they can spend with me" and "…we understand each other". However, it can also be a burden to live with other residents, especially when too many problems occur. Some had experienced intrusion into their private lives, and sexual violation has occurred. Social relations are considered important in facilitating recovery and become a barrier if they are limited.

Willpower

The service users view their own willpower to be of importance in attaining recovery and to be able to live independently. They have to make a deliberate choice to

work on themselves and decide to make changes in their lives: "…it was my own decision so it is this motivation, you have to have it yourself…". Reflections on the process of recovery also involves the service user's time and energy: "I don't think you ever get finished… you cannot say now I am completely recovered…you have to get closer and closer, it is an essential part of it [recovery]" and the will to be able to fight for recovery: "… I have been fighting like a madman; I have sent the demons on the run". Being able to make changes in one's life was viewed as constituting a precondition for recovery. "I thought I might once in a while go into the fight, and develop myself … you might as well start now, the faster you do it, the shorter time you have to be here, and then you might be able to be more independent and live somewhere else". Being able to cope with the illness was essential to many: "… I definitely believe I can learn to live with it [the illness]". The process of recovery was also characterized as involving periods of doubt and uncertainty, struggles, and periods with less faith and hope. Many hopes to get life back to how it was before the mental illness occurred: "… it is a little wish about gaining one's old life back, when you are feeling better". The process of recovery in the service user's perspectives is depending on mobilizing the necessary will power and overcome periods with less hope.

The interpretation of the service user's perspectives on recovery is related to each of the main themes derived from the phenomenological analysis.

Theme 1: Learning

In the service users perspective rehabilitation in the supported housing services gives them the opportunity to learn to recover and to develop new skills while undergoing rehabilitation. The recovery process is described as a learning process that is influenced by social relations and a personal willpower. According to Lave and Wenger participation in communities of practice gives people an opportunity to learn (Lave and Wenger 1991). The service users get an opportunity to enhance their practical and social skills when participating in the community of practice while living with others and interacting with staff. As the findings show, the goal of the learning process is to be able to manage everyday life independently and move to a place on their own. However, learning how to recover is not just a matter of internalization of knowledge. It also involves interacting with others to become an active player in life (Lave and Wenger 1991). Similar to William Anthony's definition of recovery (Anthony 1993), recovery in our study is considered by service users as an individual process of change: changing attitude, values, feelings and goals. The service users describe the changes they encounter as being influenced by participation in social activities e.g. having meaningful social relations. Learning is viewed by service users as situated in the social practice in the supported housing services, although they report on having limited access to participate in communities of practice outside services. As a result of this, everyday activities take place with staff and residents inside the supported housing services. The language used by service users when talking about their own recovery process carries certain significance in this mental health setting, when practising a recovery oriented approach to rehabilitation. The concepts used about recovery contain a discourse that is characteristic of this particular community of practice (Lave and Wenger 1991). The service users share a mutual understanding of recovery which they immediately refer to in the interviews. Interestingly, the language and the concepts on recovery correspond with the language used in the literature on recovery. Thus, the transformative discourse of recovery used in mental health literature and by staff in daily practices seems to have been successfully internalised by service users when they tell about their individual recovery process. The service users are aware of the importance of their own personal role in achieving recovery and understand the importance of help and support from others. This corresponds with the recovery-oriented rehabilitation approach which is tried implemented in mental health services in Denmark.

Theme 2: Social Relations

The service users feel they have to seek and to develop the necessary support from others to aid their process of recovery. The role of the staff is to support and motivate them in their process towards recovery. The relationship with staff is described as intimate, close, comfortable and secure. The presence of staff and other residents is generally perceived as positive; but to some, it is also a burden. Service users takes part in daily activities, e.g., cooking, shopping, and cleaning in the supported housing services. None of the service users have a job or participate in educational programs. Several service users emphasize the importance of socializing with family and friends and participating in social activities outside services. It seems to be a contradiction as they also report that they rarely are involved in social activities outside services and staff is viewed as friends and family. Everyday life has an impact on their recovery process, in that sense they receive the support they need.

One of the challenges in rehabilitation is how their current life in services relates to previous and future lives of service users (Borg 2004). Relationships to staff are described as being intimate, but also solely controlled by them. Staff is told to support their individual recovery process, but they are also in control of the services

provided. This double function can be described as a kind of paradox (Järvinen 2004). The more the professionals are involved in taking care of individual needs, the more they are described as contributing to recovery (Schön et al. 2009). A pivotal point of the recovery-oriented rehabilitation approach is to take control over one's own recovery process. But recovery studies also emphasize that social aspects has an important impact on the recovery process (Schön et al. 2009; Topor et al. 2009). Feeling connected to others outside the mental health services is pointed out as having an impact on facilitating recovery. Yet, people with mental illness are generally viewed in news media as being dangerous, and are less socially accepted. This means that people with mental illness are at risk of gaining less social support than others, although they need social contact in attaining recovery (Furukawa et al. 1999; Torgrud et al. 2004).

There seems to be a contradiction between the intentions of inclusion as described in the recovery literature and the reported lack of inclusion which could lead to stigmatization. Stigmatization means that people are not socially accepted (Goffman1963). A male service user used a strong simile to describe the rejection he had experienced from a former friend which had looked at him: "… as if I had the plague". According to the service users mental illness is viewed by many people as a taboo *outside* services, but accepted *inside* the supported housing services. Within this context the service users feel they can talk openly about their illness and about hearing voices and having delusions. As a woman expressed: "It is nice to talk openly about something that somehow is a taboo … it is allowed here". The results of the study show examples of stigmatization, ranging from service users not feeling socially accepted *outside* the supported housing services to visual examples of stigma related to their physical appearance, e.g. scars from cutting. Not feeling socially accepted in society can, according to Goffman (1963) also lead to self-stigmatization which could explain some of the difficulties service users experience when obtaining the needed social contact.

Theme 3: Willpower

In the service user perspective, their personal willpower is a prerequisite for obtaining recovery. Baumeister and Tierney (2011) point out that the concepts of will, willpower, and mental energy should be brought back into focus to help us understand why people struggle to mobilise willpower, and help understand why some have it and others don't. As this study shows, many service users had experienced turning points at which their recovery process was enhanced. Incidents of significant change increased their faith on having a possibility to recover, and this gave them back their willpower. They report having found new ways of coping with the mental illness and increased ability to take control of symptoms.

Gaining new friends or moving to a new place where they had to start from scratch is actually tantamount to progress in recovery. The recovery process is described by service users as a struggle, a fight against inner voices and delusions, and a struggle to find new ways to cope with the illness. Recovery is dependent on their determination not to give up. Sometimes they find themselves on the verge of losing faith. They have experienced critical periods where they struggle to maintain their sense of hope. According to the service users, it takes time, energy, and employment of strategies to overcome the delusions and inner voices. One important factor in maintaining a strong sense of willpower is to receive support from others. Some have the faith in God or have adopted other spiritual approaches which give them the support they needed to further the recovery process. In this case, the lack of willpower is empowered by religious beliefs.

The results of the study show that recovery is viewed as an individual process depending on personal efforts and hard work. Supported by the literature on recovery, the primary goal of rehabilitation is to allow the rehabilitee to make changes and to work actively towards recovery (Wilken and Hollander 2008). In other words, the person's own willpower is a prerequisite for achieving recovery. In this study, several internal factors that facilitate recovery are identified. These facilitating factors are related to individual capacity and the motivation to make changes and to seek help. Recovery is described as a hard and difficult process with struggles and ups and downs. One male service users had another view on recovery, he did not believe recovery was dependent on his active effort: "… I try as best as I can to be as passive as possible". This emphasize the unique individual aspects of the recovery process, people find different ways to recover.

Discussion

The results of the study show that the process of recovery is influenced by several interacting factors and related to learning, social relations, and willpower. Our study shows that recovery from mental illness is a unique and individual process influenced by interacting factors. Other studies before us have found recovery to be a unique process that depends on support from others (Deegan 2002; Topor et al. 2009; Mezzina et al. 2006). To our knowledge, no studies have investigated how service users perceive the impact of recovery-oriented mental health services on their process of recovery. The present study demonstrates how living in this particular context has an impact on the process of

recovery. However, the supported housing services are not only presented by service users as facilitating recovery; they are also viewed as a barrier. Living in supported housing services seems to isolate their residents and influence the possibility for inclusion into the community. Without suitable housing possibilities available in society, service users have less chance maintaining important life resources, e.g., developing supportive social relationships and participating in meaningful activities (Browne et al. 2008). Consequently, in the following, we will discuss the results of the study in relation to internalization of recovery, the role of staff and stigmatization as a contrast to the recovery vision of these mental health services.

Internalization of Recovery

As the results shows, the service users have internalized the concept of recovery and have a preconception of what they should do to aid their own recovery. They are well aware of having to learn new skills and make changes in their lives in order to obtain recovery. Factors facilitating recovery during rehabilitation were related to learning, social relations, and willpower. This preconception of recovery is similar to that described in the literature on recovery which emphasizes that recovery is an individual journey supported by others (Topor et al. 2009). There appears to be a correlation between insight and recovery style. Insight is related to the individual's ability to utilize internal and external resources to aid coping (Fitzgerald 2010). As our results shows a person's insight and recovery style thus contribute to the recovery process. An integrated recovery style is characterized by awareness of the continuity of self in relation to psychotic experiences, ability to make sense of the experience, and social engagement (Fitzgerald 2010). According to Fitzgerald's study, people must be engaged with services and have insight into their illness to help recovery. In our study the service users find it acceptable to talk about their illness within services. In addition, a study performed by Mueser found that psycho-education increases individuals' insight into illness and affected sociability (Mueser et al. 2002). The question is whether the internalization of the meaning of recovery influences the person's insight and ability to cope, and whether it in this way becomes an internal factor that could influence the recovery process. In our study the service users did not talk about psycho-education as a facilitating factor in obtaining recovery. In the literature gender differences is reported in how recovery is experienced. In a study by Schön et al. 2009, shows that men tend to place greater value on medication, hospitalization, and the use of one's own strategies for coping. Inversely, women often find therapeutic relationships, family support, and organized occupational activities outside the home to be more conducive to recovery (Schön et al. 2009). We can not from our study conclude, that gender plays a role in how people find ways to recover, this must be further investigated.

The Role of Staff

The results of the present study show that social relations have an impact on recovery and that the role of staff was to help facilitate this process. Recovery is what individuals do; facilitating recovery is what professionals do, and supporting recovery is what systems and communities do (Townsend and Glasser 2003). Interestingly, service users referred to the providers in the supporting housing services as their friends. This raises important questions on the providers' role in establishing social relationships conducive to the recovery journey as there may be a risk of maintaining provider dependency instead of building up new relationships in the community.

Knowledge about the lived experience of recovery viewed from the service user's perspective can help staff develop services that facilitate recovery. The identification of common strategies that are useful in the recovery process allows others to learn about these strategies and to use them. The Illness Management and Recovery Program is a standardised program based on a teaching approach (Mueser et al. 2002). In the present study, social aspects were important in facilitating recovery, but could also be a hindrance. The results show that staff plays an important role in offering support by motivating users and also simply by being there when their help is required. Our results show that support from peers could be beneficial but it also shows that it could be a burden to live with peers. The benefits of learning from peers with expert knowledge of recovery are supported by several studies (Schön et al. 2009; Topor et al. 2009). But this was not an important issue to the service users in this current study.

The experiences of recovery reported in the present study raise many questions, not only in regard to how staff and services can facilitate recovery, but also in regard to how the outside communities can help support recovery (Repper and Perkins 2003). The literature on recovery emphasizes that professionals play an instrumental role in facilitating recovery; the recovery orientation lies in the professionals' attitudes, knowledge, and skills (Farkas et al. 2005; Jacobsen and Greenley 2001; Mancini et al. 2005). Yet, there is a risk of losing the spirit of recovery when people without lived experience speak about recovery (King and Meegan 2007). There is a risk of personalizing the problems people experience and of placing the entire responsibility for recovery on the individual. As our study show will power was highlighted as a facilitating factor to recovery, but this does not mean we should leave the

recovery process to be a responsibility for the individual. As reported in our study the social contact with others outside services was limited. One of the greatest barriers to rehabilitation is when a person internalizes the idea that "I am not good enough" (Saetersdal and Heggen 2002). This can very easily lead to self-stigmatization. Shepherd et al. (2008) warn about the dangers of using a reductionist approach when formulating a concise definition of recovery. As our results show there is individual differences in what facilitates recovery. Shepherd et al. 2008 highlight that there could also be a contradiction between standardization of factors for recovery into services and the notion of recovery as a deeply unique and personal process. If services are to be influenced by a recovery vision, then a major shift in service delivery needs to occur that moves it from managed, maintenance-oriented care to self-directed care and self-management (Glover 2005). In our study the service users report their connection with staff as being friends and family, this could be a barrier for self-management when it comes to connect with others outside services.

Stigmatization

The present study shows that the efforts made by staff in supported housing services are not enough to facilitate recovery because of external barriers that foster stigmatization and exclusion. Previous studies have shown that there is a link between social capital and depression (van der Gaag and Webber 2007; Webber 2005). Social support predicts better community adaptation (Clinton et al. 1998), improved housing stability (Calsyn and Winter 2002), and the likelihood of finding employment (Rogers et al. 2004). In the present study, the service users' inclusion into society seemed to be limited while they were living in supported housing services, even if it generally accepted that participating in work and education are important for recovery from mental illness (Wilken and Hollander 2008; Farkas et al. 2008). The supported housing services can be regarded as an open institution that affords its occupants with the possibility to take part in common everyday activities (Larsen 2003). According to Goffman, institutions are characterised as bureaucratic organisations, taking care of the needs of larger groups of people (Goffman 1961). As our study show, rehabilitation as it takes place in the supported housing services, seems to do little to encourage people to participate in work and education. None of the service users in our study participated in supported employment initiatives.

Rehabilitation programs have just recently started to incorporate peer support, but little is known about the outcome and possible effect (Barber et al. 2008). Despite the efforts to maximise the efficacy of rehabilitation interventions in the direction of recovery-orientation, it seems to be difficult to maintain the recovery process outside the supporting housing context. Internalised stigma exacerbates avoidant coping and has an impact on hope and self-esteem, leading to outcomes that negatively affect recovery (Yanos et al. 2008; Kleim et al. 2008). Positive outcomes, such as self-management and self-efficacy, are not likely to be sustained as what has been learned in rehabilitation settings is not necessarily transferred to the home setting (Jerant et al. 2005). Stigmatization of people with mental illness is an issue of international concern (Davidson 2003; Repper and Perkins 2003). Campaigns against stigma attempt to demystify mental illness and eradicate prejudice via media campaigns.

The social aspects of recovery need to be investigated and supportive communities that include people with mental illness should be developed as part of the recovery oriented rehabilitation approach.

Recovery-oriented services involve partnerships with service users, emphasize choice, and instill hope (Salyers and Stultz 2007; Farkas et al. 2008). Facilitating recovery means being able to offer opportunities for people to live a meaningful life in society. As our study shows participation in social activities outside the supported housing services were limited although social relations with others were highlighted. The primary goal of recovery-oriented rehabilitation is not only to facilitate individual change and create a culture of healing within services, but also to bring about opportunities to live in an inclusive society (Wilken and Hollander 2008; Repper and Perkins 2003). Recovery involves not only the individual's emerging sense of integrity and purpose, but also society's increasing ability to acknowledge and support integrity and purpose (Onken et al. 2007). The study results from our study highlight the importance of being included in society as an facilitating factor in obtaining recovery.

The recovery-oriented movement is by some regarded as a civil rights movement which work for rights and responsibilities of citizenship for people with mental illness (Davidson et al. 2010). Not belonging, not being able to connect to others, and lack of opportunities to participate in meaningful activities emerge as barriers to recovery (Brown et al. 2008). As our results show several internal and external factors related to learning, social relations and will power has an impact on obtaining recovery from mental illness. Not only individual factors an impact on recovery but also social and environmental issues are emphasized in obtaining recovery from mental illness.

Study Limitations

The qualitative research design enabled us to gain knowledge about the service users' perspectives on recovery.

Individual interviews helped us gain deeper insights into the lived experience of recovery and allowed us to better understand the impact which living in recovery-oriented service contexts has on the individual's recovery process. A semi-structured interview guide with open questions enabled participants to talk freely about their lived experience.

The chosen theoretical frame of reference had a great impact on the interpretation. The combination of a phenomenological-hermeneutic approach to the analysis gave us insights into the participants' subjective understandings of recovery and gave the service users a voice. At the same time, it provided a tool for interpreting the findings. Participants were able to explain in detail their recovery experiences, which could have been influenced by the particular setting in which they live.

One limitation in this study is the use of individual interviews which generate limited knowledge about the context and everyday life in the housing services. A field study research design could have given us better access to get a richer description of the context. As the study went on, it became apparent that knowledge on how the context of rehabilitation affects the participant's recovery process could have been more effectively obtained by using participant observation.

The quality of the study findings was assured by using a variety of strategies for achieving validity and reliability, such as ongoing discussions of the quality of the data collection and analysis by several researchers working collaboratively together. The identified themes and the interpretations were discussed until a sustainable and valid conclusion was made. In addition, we used an audit, which helped bring forward a critical view on the preliminary findings and the interpretation of identified themes. The phenomenological approach used in the analysis made it possible to identify phenomena grounded in the users' subjective understanding of recovery and the hermeneutic interpretation helped understand the phenomenon of the lived experience of recovery.

Learning, social relations, and willpower were identified as factors that the service users found facilitated recovery during rehabilitation in supported housing. Willpower and ability to work towards recovery were viewed by users as important to recovery. Social relations, contact with family, friends, residents, and providers were considered to have an impact. However, the identified barriers: call for providers to reconceptualise the recovery approach in rehabilitation and critically assess how to reduce barriers within the context. Mental health services seem to overlook the impact they may have on recovery and the possible barriers that exist within this particular institutional settings. By focusing solely on the capability of the individual person undergoing recovery, there is a risk of overlooking barriers within services and society in general. Several studies have explored the users' perspective on recovery; however, to the authors' knowledge, the present study is the first that shows how recovery-oriented services contribute to recovery in a Danish context. As shown by our results, barriers in the context of rehabilitation in general, and in society in particular, seem to hinder the process of recovery. Despite the fact that participation in recovery-oriented rehabilitation and being accepted by staff is known to promote recovery, little is known about the barriers within mental health services and how to help service users to be included in society. Communities that actively support recovery are yet to be developed within mental health services.

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