Recovery: A Journey for all Disciplines
Contents

Foreword........................................................................................................................................2

Recovery and Nursing.....................................................................................................................3

Recovery and Occupational Therapy............................................................................................12

Recovery and Psychiatry..................................................................................................................19

Recovery and Psychology...............................................................................................................25

Recovery and Social Work..............................................................................................................34

Concluding Remarks.......................................................................................................................42

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Foreword

This year will mark the 10th anniversary of the National Mental Health Policy ‘A Vision for Change’ (2006). The Recovery principle set out in the Policy reflected a substantial shift in mental health services towards supporting person-centred, evidence-based and recovery-oriented services. The HSE Mental Health Division has been working to build capacity in mental health services and values to support person-centred, evidence-based and recovery-oriented services. The unique expertise of those who use mental health services, their families and carers, professionals and community partners is critical to ensuring the opportunity for people who use services to achieve personal recovery.

Advancing recovery focused initiatives through Advancing Recovery Ireland, ARI, including Recovery Colleges, Peer support working, the roll out of Recovery principles training, along with the Recovery work on many of our acute units and Community Mental Health Teams, are a key part of mental health service delivery. I wish to acknowledge staff and teams who have embraced the recovery principles in their work. The range of professionals working in mental health has expanded and multidisciplinary teams are providing a wider menu of interventions to address the range of issues that arise for those with mental health problems and promote better outcomes for services users with a clear focus on recovery.

The appointment of the Head of Service User Family Member Carer is crucial to promote integrated evidence based, recovery focused services and to ensure the views of service users are central to the design and delivery of mental health services.

As part of our efforts to promote the discourse on recovery we asked individual professionals to author a short chapter on what recovery means to them as an individual practicing in a particular profession. We are grateful to all those who have shared their personal understanding with us and hope that these contributions will help to expand our collective understanding of recovery and our commitment to effective partnership working between providers, service users, family member and carers.

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Recovery: A Journey for all Disciplines

Recovery and Nursing

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Recovery: An alignment of values and vision within Mental Health Nursing

A recovery-oriented approach to mental health care is now a core part of Irish mental health policy. *A Vision for Change: Report of the Expert Group on Mental Health Policy* espoused the values and principles embodied in a recovery ethos (Department of Health and Children, 2006), with subsequent documents, such as *A Recovery Approach within the Irish Mental Health Service: A Framework for Development*’ (Higgins, 2008); *Recovery: What you should expect from a good quality mental health service* (McDaid, 2013), and *Building Capacity in Mental Health Services to Support Recovery* (Watts et al., 2014), exploring and documenting both the implications for practice and some of the advances made to date within mental health services in Ireland. In the context of mental health nursing, the document *A Vision for Psychiatric/ Mental Health Nursing in Ireland: A shared journey for mental health care* identifies the development of recovery focused mental health nursing as a priority (Cusack and Killoury, 2012).

Research suggests that a core ingredient in peoples’ recovery journey is the personal qualities of the person they meet; people who believe in them, listen, respect and empathetically support (Watts et al., 2014; Kartalova-Doherty et al., 2012; Brown and Kandirikirira, 2007). Peoples’ recovery is also enhanced by those that work from a stance that enables people: develop and hold hope for the future; find meaning and purpose in their experience; promote a positive sense of self and identity beyond the label of ‘mental illness’; become involved in meaningful roles and social activities; and develop a sense of personal control, resourcefulness and agency (Leamy et al., 2011). Ultimately it is the feeling of control and responsibility that increases peoples’ confidence and self belief, which in turn
enhances a willingness to take on additional challenges and positive risks, and to trust in one’s voice and ability to overcome obstacles and recover.

**Do pre-existing values underpinning mental health nursing naturally complement a Recovery approach?**

Many of the core values underpinning mental health nursing naturally complement a recovery approach. Indeed, some of the strength of mental health nursing is its alignment with the values of care, compassion, empathy, and companionship, including nurses’ ability to be ordinary and do the ordinary thing. The values put forward by the two mental health nurses considered key leaders in the area of mental health nursing, namely Hildegard Peplau and Phil Barker, are also highly congruent with recovery principles and philosophy. Indeed, Peplau’s *Interpersonal Relations Theory of mental health nursing* (1952) is considered a seminal text on therapeutic mental health nursing, while Barker’s book on the Tidal model is frequently cited as the first recovery model to be developed by and for nurses in practice. Underpinning values in both Peplau’s (1952) and Barker’s (Barker, 2001, 2003; Barker and Buchanan-Barker 2005; Buchanan-Barker and Barker, 2008) work are the centrality of personhood, autonomy and partnership, the importance of ‘being with’ and ‘connecting with’ as opposed to ‘doing to’; and a commitment to caring about the other in a way that nurtures growth, development and potential in both the other and self. In keeping with recovery ethos, rather than being paternalistic, the Tidal model also views the person in distress as the authority on their life and problems, viewing the narrative or ‘story’ of the person experiencing distress as central to the caring and recovery process. In addition, rather than focusing on problems, deficits and abilities, in keeping with the values of recovery both authors emphasise the importance of nursing seeking to reveal the many resources, strengths and abilities of the person.

**What nursing practices need to change if mental health nursing is to become truly recovery-oriented?**

The answer to the above is not simple. C. S Lewis, in his autobiography tells a story of how one evening at dinner in a conversation with colleagues he referred to philosophy as ‘a
subject’ and was reminded that philosophy ‘wasn’t a subject to Plato, it was a way of life’. Like philosophy, recovery is not an objective action that nurses perform on another, but is an embodied way of thinking about and relating to another human being in distress. As thinking frequently frames action, change must first come in the way we nurses’ conceptualise and think about mental distress and ‘illness’ as well as the manner in which we relate to the person experiencing distress. Whilst hope is central to peoples’ recovery and may be described as the emotional essence of recovery (Slade, 2009), to nurture and support recovery processes, we need more than a belief that recovery is possible (Barker 2001), we need to work in new and creative ways so that the service we offer is both person oriented and rights based.

While certain guiding principles are gaining consensus, such as, the importance of providing a service founded on hope, connection, meaning and empowerment; recovery is also a critique of current service provision, and as such is a critique of nursing services. Recovery narratives clearly indicate that people are not just recovering from the original life circumstances that gave rise to their mental distress, but are also recovering from the impact of coercive, oppressive and paternalistic ‘psychiatric’ practices and from the consequence of the loss of rights and voice that often ensue from being labelled ‘mentally ill. Developing a truly recovery oriented nursing service depends therefore on the confluence of a number of factors all of which are not easily amenable to change (Higgins and McGowan, 2014), including shifts in attitudes, power relationships and practices that includes a willingness and commitment by nurses to:

- Engage in a ‘relational narrative’ or dialogue with the person and family, that acknowledges the common humanity of all and is guided by a commitment to the values of cooperative enquiry and co-production, rather than an objective detached style of interaction that characterises many current ‘clinical’ encounters (Gadow, 1994).
- Value and listen actively to the person’s story, with a view to exploring alternative meanings and explanations of the person’s distress. The aim of this is not to have ‘one voice’, that frames issues and problems within the language of diagnosis and symptoms, but to express contradictions and open the possibility of new perspectives. Whilst
diagnosis is important for some people, other people do not find it helpful, arguing that it is oppressing and simply another way of exercising professional power by dismissing the voice and experiences of the person experiencing mental distress (Watts et al., 2014).

• Change the relational dynamic from one where the person is a passive recipient of the nurse’s wisdom to one where the person is seen as the expert in their life story. In this context the we need to facilitate the person to tell their story and talk frankly about feelings and experiences, while creating a context for telling, through ‘natural curiosity’ and the asking of ‘interesting questions’ (Stevenson, 2003:100). We also need to become an ‘apprentice’ (Buchanan-Barker & Barker, 2008) learning from the person what needs to be done. Indeed, Barker (2003) argues that using the language of the person is the simplest and most powerful form of respect for the person.

• Support the person to build self-determination, autonomy and responsibility in decision making, by believing in the person’s own resourcefulness and abilities, focusing on the person’s strengths, abilities, and resilience as opposed to inability and disability, and working with the person in a way that promotes choice and develops personally meaningful goals with the person.

• Relate to the person not the diagnosis and develop strategies with the person to enable them to counter internalised shame or stigma, as well as strategies to counter stigma or discrimination experienced from others.

• Create a supportive environment that is challenging and stretching of the person’s ability and one that promotes and supports positive risk taking. In this context we need to view set-backs as opportunities for growth and learning as opposed to failures (Higgins et al., 2015), and reflectively guard against the desire and need to take back control.

• Assist people to connect with meaningful and satisfying social roles within local communities, by working with a range of services outside of the mental health services, including educational, employment and recreational organisations and agencies.

• Maximise therapeutic contact time with the person and family, by becoming skilled in recovery oriented practices such as wellness recovery action planning, trauma informed nursing care, crisis planning, and co-facilitated models of education.
• Work in partnership with peer support services, and be proactive in informing service users and families about peer services.

• Recognise that people experiencing distress have the right to make informed decisions about their care and treatment, and be proactive in providing information based on the best evidence available, including information on the pros and cons of all options available.

• Review our nursing practice and be committed to moving away from practices such as search procedures, locked doors, seclusion, restraint and forced medication as they are experienced by service users as retraumatising, paternalistic and disempowering (Watts et al., 2014).

• Adopt a proactive stance in identifying difficulties the person may experience with prescribed medication and be willing to explore the possibility of people living a medication free life.

• Support the person and/or family if they wish to use their experience as a source of positive inspiration and resource for others, or become involved in peer or advocacy activities. Involvement in such activities help develop positive and empowering identities (Mancini, 2007).

• Consider that the family in many situations is the unit of care, and engage with and support family in their own recovery journey, so they can support the person experiencing distress in their recovery.

• Recognise the difference between a care plan and a personal recovery plan. A care plan is what treatment and support a person will receive from services, and it is often developed and led by the nurse and multidisciplinary team. A personal recovery plan, in contrast, is focused on how the person will take control of their own life, and is developed by the person, with the nurse playing a support role in its co-production.

• Recognise that there is no right or correct way to recover, as each person’s journey is unique. Whilst decisions made should always be based on the best available evidence, which takes into account the person’s preferences, there needs to be an appreciation that there cannot be a prescribed protocol, framework or guideline for recovery that is applicable to all.
Recovery also embodies political and social justice goals. It is a narrative that shines a light on the urgent need to challenge the inequalities, injustice and oppression that prevent people labelled ‘mentally ill’ from leading socially integrated and inclusive lives. We, can play a leadership role in this area by:

• Proofing nursing policies and procedures to ensure that they reflect the values of recovery and recovery oriented nursing, and support person centred and rights based approaches to decision making

• Considering how the language of ‘psychiatry’ and ‘nursing’ can be a tool that enables the exercise of power, perpetuating traditional power relationships between the nurse, the person in distress and their family; and challenge and change both their own language and the language of practice.

• Challenging inequalities both within and outside services, highlighting the causes and consequences of stigma, discrimination, and social/economic exclusion.

• Supporting and advocating for the development of and inclusion of peer led services and the involvement of peers in the development, delivery and evaluation of services and educational programmes for nurses.

Recovery is not just a journey that is applicable to people experiencing mental distress but is also relevant to the internal life world of the mental health nurse. Practitioners working in the mental health service have noted that ‘service providers sometimes need to recover their own sense of value and dignity as caring human beings’ and be more open to people who work within services who have experienced mental health problems (Watts et al., 2015: 70). For mental health nurses to be in a position to ‘bear witness’ on an ongoing basis to the lived reality of people’s distress and move to a position of emotional connectedness and interpersonal presence, nurses we the emotional space to:

• Finely-tune our self-reflective skills so that we are consciously alert to the inherent power differential that is pervasive within ‘clinical’ type relationships with people who experience mental distress.
• Engage in ongoing reflection in order to minimise risk of compassion fatigue and emotional disengagement.

• Address our own distress, and feelings of despondency, guilt, or professional hopelessness when people continue to experience distress, and require emotional and practical support on an ongoing basis.

• Cultivate the moral courage to challenge institutional, professional and personal systems, procedures and practices that work against the development of recovery oriented nursing practice.

In conclusion, many different strands of policy, practice, education and research must come together if we are to build the respectful, collaborative and empowering service that the recovery movement envisions and which people experiences mental distress, their families and practitioners request and have a right to experience (Watts et al 2015). Mental health nurses have close and continuous contact with service user and family members and are in an ideal position to influences the persons experience and perspective of their encounter with mental health services and recovery outcomes. We are also the largest professional group working within the mental health service and work across a variety of setting (DOCH, 2006), consequently we are ideally positioned to lead and shape the wider culture of the mental health services and make a major contribution to the development of a truly recovery oriented service.

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Recovery: A Journey for all Disciplines


Recovery and Occupational Therapy

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Introduction

Occupational Therapy can make an invaluable and extensive contribution to the Recovery Agenda (Dowling and Hutchinson 2008). The Recovery movement has both challenged and supported Occupational Therapists to fully engage with the values of their profession. Occupations are the daily tasks that we engage in because of the meaning or personal value they provide us with. They are constantly evolving and individualised in each context (Kramer et al 2003). The Recovery Approach is about building a meaningful life which is synonymous with the philosophy of occupational therapy.

As a discipline, among our MDT colleagues, we have for a long time been at the forefront of promoting both the concept and practical implementation of placing the individual at the centre of our work. We could become comfortable in that role. However, it is the Recovery Approach which now challenges us further and does not allow for complacency. As Occupational Therapists we need to continue to shift our work practises to fully adopt a truly recovery-oriented approach and move from being a person-centred discipline to being person-led in our approach. This enables us to value the perspective of the person above our ‘objective’ clinical perspective, when safe to do so.

Acknowledging all parties as both peers and experts is an important aspect of supporting the process of being person-led. We are all Occupational Beings, which allows Occupational Therapists to implicitly and explicitly identify as peers. The focus of occupational therapy can often be on the realisation of self through occupational transformation. Occupational Transformation is at the core of discovering a sense of personal identity beyond illness or
Recovery: A Journey for all Disciplines

disability. The founding blocks of hope, belief, empowerment encompassed within the Recovery Approach are also the foundations of occupational therapy.

Recovery for all

As Occupational Therapists we need to support our own wellbeing if we are to support the recovery journey of another individual. Occupational Therapists have needed to be cautious in ensuring that the people we see do not merely become products of our own occupations (Bryant et al 2004) or that the outcomes of the people we work with become the measure by which we see ourselves as therapists. By emphasising a partnership approach and moving away from ‘a helping relationship’, Recovery Principles support us to focus on the process of our therapy, without predicting outcomes or taking responsibility for what people do. Occupational therapists and those using the service will continue to need to recognise the reflexive nature of these relationships, and how both persons’ wellbeing will impact on the quality of this.

Occupational Therapists have demonstrated our commitment to wellness and supporting each other by our longstanding work practices in clinical supervision and peer support. The values of recovery principles do not simply get ‘turned on’ when we are working with someone accessing a service, but rather become embedded in the way we approach our team members and colleagues. Recognising that organisations and teams need to ‘recover’ as much as the individuals who use them or work in them, is an important aspect of truly embracing the principles of recovery at all levels. However, the change within an organisation can start to happen when individuals embrace their individual skills and attributes to have an impact.

Personal Attributes

Use of self in therapy and particularly recognising that our personal qualities contribute to this, creates a crucial need for us to identify our personal values in contrast to those of our profession. Provision of professional services is an obligation and expectation of those
employed as Occupational Therapists. Part of occupational therapy work practice has always been to bring ourselves to the therapeutic relationship, while recognising that standards of professionalism also support the work. The interaction between the Occupational Therapist and the person using the service is always unique, and this means that those personal attributes can both support or diminish the value of the therapy. In cases where we are aware that the personal attributes diminish the therapy, the perspective and philosophy of occupational therapy can be more heavily relied upon to ensure the quality of the work. It may also be important to appreciate that professional training and professional experiences can support the development and enhancement of personal attributes and values. For the personal attributes of therapists to be fully realised, the values of the therapist must be communicated in every interaction that they have.

Language of Recovery

The language we use within therapeutic work, within teams and with our colleagues reflect our understanding of our roles and values. As Occupational Therapists we use language related to individual strengths rather than deficits, to wellness rather than illness. This is reinforced by the Recovery Approach. We have in the past, adopted the language of more medical systems to ‘find a place’ or justify our role. The recovery movement has allowed Occupational Therapists to reconnect more easily with the language of our discipline in a way that our teams are more likely to understand. Occupational Therapists have easily adopted the language of recovery and due to the philosophies of occupational therapy and recovery having a lot in common, it has breathed new life into a language that we can share with all stakeholders. The power of having a positive strength based language creates a new perspective on how teams may view individuals who access the service and it should not be underestimated. This can enable us to discuss the situations of people we work with in relation to what their aspirations are as opposed to any perceived deficits.

However, the risk of focussing primarily on language is that the true value of the narrative of recovery can become tokenistic and delay the reform of service provision. People without a belief in recovery can use the language to hide behind, rather than embrace its lived
practise. At times, the preoccupation with saying the ‘right’ thing dominates the importance of the intention behind what we say. Inevitably we will take different meanings from the same words, but ensuring that we share an understanding of what we are trying to express is often more important than the semantics. Occupational Therapy has always struggled with their interpretation of occupation being different to the more common use. The word recovery itself is another example of this as it can also be used to describe the amelioration of symptoms.

‘Goals are dreams with deadlines’

The tension that exists between hopes, dreams and aspirations and the pragmatic realism of goal setting is a tight rope that is walked by therapists. Endeavouring to increase the prospect of success by identifying barriers while not reducing positive expectations of what people can achieve can challenge therapists endeavouring to be recovery oriented. Occupational Therapy is synonymous with goal setting and the breakdown of tasks into achievable parts. The process of breaking down a task supports individuals to be effective agents of change in pursuit of their dreams. Planning and committing to change is a component of the hope filled approach of recovery (Schrank and Slade 2007).

Social Inclusion

Occupational Therapists are not just concerned with the process for individual but with the environments that individuals are part of. As Patricia Deegan (1996) wrote:

‘The Goal of Recovery is not to get mainstreamed. We don’t want to be mainstreamed. We say let the mainstream become a wide stream that has room for all of us and leaves no one stranded’ (pg 92).

Occupational Therapists work with people with or without specific diagnosis or disability. This allows us to work in contexts outside healthcare. It has always been the natural approach of the Occupational Therapist to support the connection or reconnection of
Recovery: A Journey for all Disciplines

individuals to their local community and to natural support structures. However, this work has generally happened within a mental health system which has fostered dependence and segregation. Therefore, Occupational Therapists struggle in delineating between our loyalty to our team versus loyalty to our profession or service users in working with services and systems that were established without social inclusion being a priority. In order that Occupational Therapists can be part of the group that lead the way in making our organisations more socially inclusive, we are compelled to recognise ourselves as being as responsible for that system as the rest of our colleagues. If we separate ourselves from the system, we do not embrace the opportunity or skills we have to change it.

The Recovery Approach places an emphasis on social inclusion and building community capacity. The Recovery approach is increasingly becoming the expected norm within mental health services. Mental Health Teams have made progress in becoming more community based. As teams, we can become complacent due to our relatively recent move to be more community based. There is a risk that being community based has meant that sit within the community, but not as part of it. The Recovery Approach makes work to expand the capacities of the natural networks and supports within our communities a central concern for mental health teams. This allows Occupational Therapists to embrace more opportunities to work more collaboratively with all stakeholders, and ultimately impact on the social environments that individuals contribute to. This means that the challenge to change working practises and integrate any individual who experiences mental health challenges, can become a three way collaboration between community agencies, mental health and individuals with lived experience.

Opportunities for leading positive change

Occupational Therapists are increasingly taking on roles within their teams and services to lead out on community facing recovery programmes and projects. Across Ireland we can see Occupational Therapists championing recovery and warmly welcoming collaboration with people with lived experience. Occupational Therapists have had a crucial role in supporting the growth of co-production, partly because of our established team role in
group work. Through the partnership approach of occupational therapy, the skills and abilities of an individual, identified through therapy, can then more easily be translated into roles as peers and co-facilitators. The future role for occupational therapy may be in continuing to embed this within OT training and also in supporting colleagues to embrace co-produced and peer led initiatives.

As Occupational Therapists increase in number and grow in confidence within our teams, we can also bring a unique perspective on challenges such as risk assessment and contribute to Multidisciplinary Team triage and assessment. Occupational Therapists have demonstrated considerable skills in balancing the act of repeatedly putting our heads above the parapet, while continuing to work supportively alongside colleagues who don’t currently understand, accept or encourage the recovery movement. Bridging the perceived risk of peer led and recovery work, while also understanding and valuing a more clinical perspective has given us a sometimes under recognised role in working with both perspectives. Occupational Therapists are often amongst the people who name things, suggest things and report back on experiences repeatedly, in order to start the process of normalising conversations about recovery. Being the person occupying the middle ground, at a time when there are two extremes of opposing views in relation to recovery can be an arduous task. Occupational Therapists may benefit from naming this within our teams and within the recovery peer led projects, such that we can more readily access support and expertise from both perspectives to take on this role more effectively.

Given our skills and experience in this area, we have to ask why there is not more sharing of our learning with the wider community. Occupational Therapy has not always fostered a culture of pursuing research or publications, but this may be something we need to revise to support the Recovery Movement and our own profession within it.

Occupational Therapists have enjoyed a position of believing that our philosophy fits well with that of the Recovery Approach, and therefore that we are in a position to support the shift of services to be more recovery oriented. However, have we focussed more attention on supporting others to make that shift than we have on evaluating what transitions our own discipline needs to make? Have we become too comfortable in this role? As Occupational Therapists we have the opportunity to lead on positive changes provided we
continue to be mindful of the development that is needed within our own discipline to be fully recovery oriented.

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Authored by: Dominic Fannon, Consultant General Adult Psychiatrist with a special interest in Rehabilitation.

Key Organising Principle of Psychiatry

Personal recovery, that is living a meaningful life even in the presence of ongoing symptoms and difficulties, has become central to health and social policy, to the regulation of services and to best practice (e.g. NICE guidelines). Although the evidence shows that clinical recovery (the reduction or elimination of clinical symptoms) is achieved in the majority of people with mental disorders, personal recovery has until comparatively recently been seen as irrelevant to psychiatry. Now, however, personal recovery is regarded as a core component of modern mental health care. The importance of the social dimension of therapeutic relationships in psychiatric therapeutic care parallels similar findings in other fields, including education, children’s services, in social work and physical healthcare.

“... in the last two decades, we have made great strides in understanding mental illness. Gone are the ideological disputes of previous years. Research has instead shown that both biological and social factors are involved, and we have learned that a diagnosis of schizophrenia does not predict inevitable decline.”

Robin Murray (Schizophrenia Commission, 2012).

From ‘What’s the Matter?’ to ‘What Matters to You?’

Historically, the practice of psychiatry has been characterised by a focus on deficits with treatment approaches, both drug and talking therapies, designed to remove or limit symptoms in order to completely resolve or minimise impairments as far as possible. An exclusive focus on deficits or impairments presents a number of difficulties for both patients and professionals. Most obviously the ‘deficit’ idea of mental ill health tends to reinforce an unrealistic and negative outlook on patients and further undermines the individual’s sense
Recovery: A Journey for all Disciplines

of control. Similarly, it can contribute to an unrealistically pessimistic outlook in the practitioner and also tends to presume an exaggerated level of control and perhaps even responsibility, on the part of the professional. It has also been argued that the deficit view has limited progress in the development of new effective treatments for mental illnesses.

An alternative approach within psychiatry identifies individual patients’ strengths and emphasises their positive personal and social resources. It is in this context that personal recovery is most meaningful in psychiatry and consistent with a formulation of mental wellbeing rather than of mental disorder.

“Mental health is a state of wellbeing in which an individual can realise his or her own potential, cope with the normal stresses of life, work productively and make a contribution to the community.”


Future direction of Mental Healthcare

Recovery focussed mental healthcare represents the next step in the development of psychiatric services and is what patients actually want. At the same time a recovery approach is consistent with the guiding values of all ‘healing’ professions and can improve the quality of, and satisfaction with, professional practice. Adopting a recovery focussed approach is also consistent with developments within medical disciplines generally where there is a greater recognition of the importance of collaboration and partnership with patients and their families. A more collaborative approach to mental health care provision has been shown to lead to a range of positive outcomes for service users and family members such as improved quality of health care, higher levels of satisfaction with services, increases in users’ participation in treatment and improved health outcomes for both patients and family members. Recovery focussed practice is firmly based in the evidence for effectiveness for a number of interventions. Evidence of effectiveness has been demonstrated for specific recovery focussed interventions including individual placement and support, Wellness Recovery Action Planning, user empowerment, personal budgets and peer support and interventions to support staff wellbeing, amongst others.
Recovery: A Journey for all Disciplines

“Recovery ideas should form the guiding principles to govern the future development of mental health services”

Recovery is for All (2010)

From Theory to Reality
In the Irish context personal recovery is proposed as a realistic possibility for people diagnosed with a mental illness based in part on research and practice guidelines (for example guidance documents from the Mental Health Commission), evidence of the experience of recovery within cohorts of people in Ireland, indicators of what a Recovery service could look like and attempts to develop recovery oriented service improvement change models.

“Recovery is probably the most important new direction for mental health service. It represents the convergence of a number of ideas (empowerment, self-management, disability rights, social inclusion and rehabilitation) under a single heading ...”

Recovery is for All (2010)

Policy into Practice
There is an emerging consensus that recovery is not a linear process but a personal journey that involves a change in attitudes, beliefs and skills in order to live a hopeful and meaningful life. Amongst the conceptual frameworks proposed for understanding and operationalising recovery are the presence of the triad of ‘hope’, ‘control’ and ‘opportunity’ identified for the service user, and the concept of ‘reconnecting with life’. A more robust conceptual framework based on a systematic review and narrative synthesis of the literature and international guidelines comprises the following five recovery processes: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (Leamy et al, 2011). Irrespective of which particular framework is chosen, it is apparent that fundamental changes will be required in how psychiatrists operate in order to accommodate the recovery approach.
A number of publications are available to inform and guide psychiatrists, for example ‘On the Road to Recovery’ (2013)- a paper co-produced for the College of Psychiatrists of Ireland by those with lived and professional experience of mental health problems - clearly illustrates the challenges and opportunities for psychiatrists. ‘Recovery is for All’ (2010) a consensus statement by psychiatrists working in the UK outlines the implications of working in a recovery focussed way.

“[Recovery] will require that the psychiatrist’s practice changes from a traditional biomedical approach which focusses exclusively on presumed deficits in the patient to an approach which involves working alongside people who use services, family members and carers to support patients to ‘get on with life’”.

In addition to a different way of working with service users which involves greater collaboration, recognition of personal strengths and resources, it is necessary that psychiatrists also think about patient outcomes in a different way. This means considerations other than clinical recovery.

“Estimation of treatment effectiveness is determined in terms of the impact on the goals and outcomes that matter to the individual service user and family member- this does not necessitate abandoning our traditional medical skills of assessment, diagnosis and treatment”

Recovery is for All (2010)

Psychiatrists and Leadership
Despite the publication of policy papers, the availability of guidance documents and a substantial research literature there is little evidence of significant development of professional practices or of whole system change in mental health services to provide recovery orientated supports. There are a number of possible reasons for the failure to translate mental health policy and evidence based practices into services, such as a limited understanding of recovery principles and how to operationalise this approach, limited
capacity within services for meaningful service user and family member partnership, current governance arrangements within services and limited research evaluation of professional practices. Some evidence is provided by a study exploring the experiences of service users in a mental health team in Ireland using a structured questionnaire to evaluate the personal meaning of recovery and the role of professionals and services (Shah et al, 2014). This demonstrated that support by other people, including mental health professionals is an important part of recovery but the quality of relationships with professionals was less supportive of recovery as perceived by service users. The findings of another recently completed evaluation of a recovery focussed quality improvement initiative in a number of mental health services in Ireland is revealing (Watts et al, 2014). Professionals interviewed acknowledged that their own attitudes and knowledge, the inherited culture of the mental health system, and prejudice among members of local communities were significant barriers to recovery focussed practice. Professionals also recognised that the variability in the quality of staff can result in negative experiences for service users and their families and that professionals themselves needed to change to become recovery-oriented. If staff don’t believe in recovery, or aren’t hopeful themselves, it is very hard to develop positive and hope inspiring relationships with patients. Another key finding was the perceived importance of leadership from the senior psychiatrist for services to move forward in a recovery-oriented manner, to drive changes in practice and in the development of the correct organisational culture. It is evident therefore that leadership provided by psychiatrists will be needed in order to embed new recovery oriented practices in mental health services.

“[necessary change from] a custodial type of relationship with service users, where responsibility for well-being lay with the institution and professional, to a professional role where decisions were made in collaboration with service users and control was progressively handed back to the service user...”

Building Capacity in Mental Health Services to Support Recovery (2014)
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Other references available on request.
Recovery and Psychology

Authored by: Pádraig Collins, Senior Clinical Psychologist, Health Services Executive.

Recovery, as is often stated, occurs in relationships (Borg and Kristiansen, 2004). If so, what is the nature of Clinical Psychology’s relationship with the Recovery movement? In this relationship what is it that we offer each other? And in what way, as in any partnership of equals, can this relationship work well for both parties? In thinking about this, I’m left with the sense that despite hanging around in similar circles for quite some time, Clinical Psychology and Recovery, in Ireland, are only really now beginning to get to know each other properly. As in every relationship, this may well involve certain disappointments (“why can’t he/she just be more like this…”) but also the opportunity to learn more about each other, to challenge each other, and to hopefully build a better future together.

Before we met...

Once upon a time, the task of mental health professionals and academic researchers seemed relatively straight-forward. Classify and categorise the different varieties of mental distress out there, establish threshold boundaries between being ill and being well, and then empirically test out what makes people better. Various versions of DSM and ICD set out the ever evolving and ever revising category list of ‘disorders’. Increasingly, particular disciplines set about demonstrating (through randomised controlled trials – RCTs, and then meta-analyses of RCTs) that their particular interventions, their medications, their psychological therapies, were ‘effective treatments’ for these particular ‘disorders’. This helped make the case for more of these interventions and, of course, for more of the related professionals to be employed.
Recovery: A Journey for all Disciplines

The unfortunate reality, however, was that even within the classical research paradigm it was increasingly apparent that these interventions were quite limited. Even putting aside the considerable evidence for damaging side-effects, ‘non-compliance’ and drop-out rates for these interventions, investigators were forced also to concede that the majority of people were simply not getting better as a result of specific interventions. I.e. in research terms, the “numbers needed-to-treat” (NNTs) for even the best interventions ranged from 3 to 10 (Wesyon & Bradley, 2005.; Wampold, 2007.; Arroll, et al., 2009, Hodgson et al., 2011; Ketter et al. 2011). I.e. even with the very best interventions three people need to be treated with this drug/therapy for one person to demonstrate a clinically significant improvement. So, the very best we could say was that some of medications and therapies were working, some of the time, for some of the people.

But even more striking, the research evidence that was coming back indicated that even if these interventions weren’t working that well, in the long run the majority of people were clinically recovering anyway, even with diagnoses that previously were deemed to be chronic and unremitting (Cf Slade et al., 2008, for a review of the longitudinal evidence relating to Schizophrenia). So people were recovering, even if it was clear that it wasn’t exclusively, or often primarily, down to the work of mental health professionals. This research would appear to indicate the need for a high level of humility, and the need to be curious, to learn from others, as to what was helping to promote recovery.

Personal Recovery – ‘first love’...

Thankfully, others on the margins of the mental health community have long championed a different approach than that of the expert ‘diagnostician-therapist’. The Recovery movement’s emphasis on partnership - recognising the vital expertise of the service user and their family/carers - and the real potential in everyone for growth and Recovery, has resonated with many within the Clinical Psychology movement for some time.
Perhaps this is in keeping with Clinical Psychology's long and positive history of challenging the status quo and thinking regarding "mental illnesses" and their 'cures' (cf Fay Fransella, 1975 to Mary Boyle, 2002; Richard Bentall, 2009; David Pilgrim, 2012). Psychologists have consistently placed the relationship at the core of any positive outcome between the person providing the service and those receiving it (Rogers, 1958; Luborsky, 1976; Kivlighan, 1995; Fonagy, 2009). Similarly, Clinical Psychology has long been interested in power and its uses and abuses in mental health (cf: David Smail, 2005).

It is therefore perhaps unsurprising, if still noteworthy, that a significant number of the leaders in the Recovery movement (Pat Deegan, William Anthony, Rachel Perkins, Mike Slade, Geoff Shepherd) are all Clinical Psychologists. The emersion in psychological and social theory along with research methodology has perhaps equipped many in our discipline with a means of giving voice to the concern that the old way just isn’t working (and also maybe ethically just isn’t right!).

The reality of relationships – the reluctant bachelor / bride.

As we know, moving into any real relationship means change and making compromises – rarely an entirely comfortable stage. Clinical Psychology itself, after the first flush of enthusiasm about Recovery, has at times being reluctant ‘get in too deep’, feeling that this relationship may all be moving a bit too fast for its liking and wanting a bit more ‘evidence’ before committing to the mortgage.

For Recovery-advocates there therefore remains a concern that many Clinical Psychologists still imbibe and promote the discourse of pathology and cure by experts. This is also a concern that in establishing itself within a conservative system Clinical Psychology may have lost its capacity to challenge (‘has Psychology been ‘captured’?’). The concern remains that, if this does not change, the people with whom we seek to develop partnerships may no longer see any merit in what we have to offer. Conversely, in response to this reluctance,
many have also taken up the gauntlet of rigorously evaluating Recovery-oriented ways of working. Something which has resulted in a significant body of traditional ‘evidence’ being amassed (cf: Slade et al., 2014).

In this regard, it is also worth noting that these changes are perhaps only a small part of the broader changing nature of the ‘doctor-patient’ relationship across healthcare. This is an international phenomenon explored by others (cf: Akerkar & Bichile, 2004). In essence they report how a more empowered, assertive service-using community are no longer passively accepting the interventions offered but demanding real partnership, a reality to the idea of ‘nothing about me, without me’. Access to high quality information from credible sources online and through peer networks, is leading to the deferential attitude to the ‘expert’ being increasingly replaced by an insistence on a partnership that respects individual’s own ‘expertise by experience’.

**Recovery – committing to and deepening the relationship**

All long-term relationships do, however, require a certain degree of commitment. What can facilitate this is the recognition that such commitment results in significant rewards.

In this regard, the Recovery movement is rich for opportunities for Clinical Psychology to promote and progress many of the values that we in the profession hold as important. Our long-standing therapeutic focus on *collaboration* takes a service-wide form when we seek to engage in *co-production* on major service developments and transforming the culture of mental health services. Our belief that our work should be led by the service-user with our expertise being ‘on tap and not on top’ (Churchill, 1964) finds practical form in developing peer-led groups and Recovery Colleges. Our belief in being evidence-based sees its truest manifestation in practice-based evidence i.e. regular local audits of service users on “whether this service is working for you”. Similarly the value we place on the individual’s own personal meaning and experience of their distress and recovery, lies at the heart of Recovery-oriented care planning.
Similarly, to deepen any relationship can require moving out of one’s comfort zone to make a step in the direction of the other. There are challenges that Clinical Psychology may need to face if it’s to truly embrace and lead in the Recovery movement, including examining some core questions about our role. I.e.

Role definition:

‘A partner to Recovery’ may involve a quite different emphasis in our work to that of the expert Psychology practitioner. There will be times when our traditional psychotherapeutic skills are indeed the most appropriate and beneficial ones to use. Other times, however, using our education, our networks of influence, our knowledge of the system to facilitate someone in getting decent housing (as this quite simply may be the single greatest contributor to positive mental health) may better promote Recovery. In such cases are we prepared to question the boundaries of our role? A similar debate has already begun about the role of traditional psychotherapeutic boundaries e.g. self-disclosure, and whether these too need to evolve in the context of the challenge from the Recovery movement (see Ruddle and Dilks, 2015).

Relationship to language, knowledge and power:

If language frames our ideas, and our ideas frame our actions then the language we use is vital to our work. In this regard, concepts such as psychiatric diagnosis pose significant challenges to us. Are we prepared to take on board the risk of causing harm through using language that can be reductionistic, decontextualising, empirically questionable and potentially disempowering (see the Position Statement by the Division of Clinical Psychology, BPS, 2013 for an extended exploration of this)? If so, are we prepared to explicitly state that the fact that we do not diagnosis or use diagnostic terms is not through a deficiency in training but as a direct result of our extended training? And conversely, where service users and family members state that, in their context, in their family culture,
the use of such terms are helpful as a communication tool, are we prepared to question our own stance on these matters and adapt to meet the need of the people in front of us? In essence, can we mindfully use language to empower others in the pursuit of Recovery rather than as an exertion of our own power and wish to demonstrate our expertise?

Research process:

Similarly if we are to retain as a core identity that of being ‘scientist-practitioners’ are we prepared to evolve our research methodology to meet the feedback of others. I.e. can our research move from being a esoteric process where a small community of professionals select research questions of interest to them, use research methodology they have devised, outcome measures they have created and chosen, then peer review exclusively in their own midst and publish in journals they alone read, all with little to no direct involvement of the communities who this research is ultimately supposed to benefit? As explored in greater depth elsewhere (Collins & Crowe, 2016), can there be a role for the people who use our services, and those who support them, to be active partners in the research process from beginning to end?

Openness to feedback:

It is a familiar mantra that ‘communication is the bedrock to any good relationship’. And yet the line of communication between us as a discipline and the service-using community (and supporters) has been largely restricted to our consulting rooms. It is clear when engaged in co-production of service development plans, or in co-designing particular Recovery courses, that the dialogue that arises is entirely different from that of the consulting room. If this relationship is to flourish then we may need to also step outside of our offices and meet people as partners in a context other than that of psychotherapy. There is much for us to learn in this regard. This openness to dialogue can complement the need to systematically audit ‘service user and family member experience’ of our services, the results of which should inform further pieces of co-production. In this regard, it is incumbent upon us to use
our research skills to support our services in knowing (a) what people who come and see us truly think of what they receive and (b) how ultimately they would like us to relate to them.

Recovery – Parting Thoughts

Clinical Psychology, like many disciplines in mental health, is at a crossroads. On the one hand, it can be reasonably argued that like other professions it has effectively demonstrated its value. Using traditional research paradigms it has shown that its therapies are effective in easing distress across a wide-range of disorders (e.g. NICE, 2011). Its workforce numbers continue to rise and the demand for ‘talking therapies’ continues to be strong within our communities. Any yet, there are certain foundational issues posed by the Recovery movement that question the core purpose of what we do as a profession. Who defines the boundaries and categories of mental distress? Who decides what constitutes a ‘good outcome’? And can a ‘helping relationship’ truly exist without genuine partnership between equals? The tension these questions create, and the need for us as a profession to reflect and respond positively to them, may well define the future of our relationship with the Recovery movement and therefore, in many ways, the future of the profession itself.

REFERENCES


Recovery and Social Work

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Why the principles of recovery are of value to social work

The principles of recovery are of value to the social work profession because of the many overlapping principles and parallels that occur between the ethos and values found in social work and the ethos and values found within the concept of recovery. The internationally recognised definition of social work reads, “Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing” (IFSW, 2014). From this definition it can be seen that the concept of recovery echoes the core values of human rights, social justice and respect which are intrinsic to social work. In this respect, the principles of recovery are of great value to social workers in the mental health service and are principles that we should be advocating for and embedding in our day to day practice.

How certain pre-existing values and work practices of social work naturally complement a Recovery approach

The mirroring of social work principles and the fundamentals of recovery can be found in the following ways;

1. A Social Understanding of Mental Distress

The original concept of recovery was used by users of mental health services as a means to challenge the medicalised approaches to mental health care (Morrow, 2013). In the sense that the original concept of recovery emphasised a social understanding of mental distress
and of social approaches to mental health, principles of social work and recovery have much in common. In a 2015 report, service users clearly identified that social approaches to recovery are vital to recovery from mental distress. The project found that, “…most service users who took part in the project feel that social approaches to mental health, which take account of the whole person and wider societal issues affecting them, are the most helpful” (Beresford, Perring, Nettle and Wallcraft, 2015: 7). This holistic understanding of people’s experiences and the interaction between the individual and their environment is intrinsic to the practice of social work in mental health.

2. Empowerment and Partnership

As Anthony (1993) advises, “Recovery is not something that professionals can do to the person, it is something that service users do for themselves” (in Higgins, 2008: 7). Social work emphasises this concept of empowerment as a core function of our work. Social workers work in true partnership with people, we aim to work in collaboration with people, alongside them as opposed to “to” or “for” them. To me therefore, the concept of recovery is something that is integral and core to the area of mental health.

3. Collective as opposed to Individualised

As a social worker I view recovery as a wide and encompassing concept. When I think of recovery in mental health, I think of recovery as it pertains to the service user, of the recovery of the carer(s)/family(s) and of the recovery of whole communities such as the Traveller community or Black and Minority Ethnic (BME) communities. I think of the recovery of marginalised populations such as lone parents experiencing mental distress, of the homeless population, of older persons and younger persons. I also think of the recovery of mental health professionals, in so far as those who work in the helping professions not only need to be proficient in providing recovery-oriented services, they also need support and compassion while they strive to deliver these services.

From my perspective, the concept of recovery in mental health is a collective issue. In social work in general, the notion of understanding individuals in the context of their environments, of the interactions of various systems e.g. environmental, cultural, economic, social, political and the impact those systems have on the individual are fundamentals of the
theoretical underpinnings of the work. As noted by Higgins (2008: 7), broadly-speaking half of recovery literature focuses “...on the iterative relationship between the person’s experience of recovery and the organisational/societal conditions that may facilitate recovery”. As a social worker therefore, while recovery can be experienced as an individual journey, it should not be individualised. In other words, social workers view recovery in mental health as involving not only individuals but families, communities and services, all interacting on multiple levels. To me, recovery is the responsibility of everyone and involves complex dialectical interactions between individuals and the systems they belong to and vice versa.

4. The Right to Participate

Another core function of social workers’ ethics is to promote the right to participate (CORU, 2011). The Department of Health and Children (2006) and Mental Health Commission (2005a) advises that ensuring people’s right to participate in society is core to the recovery approach, “...the recovery approach acknowledges the person’s rights to meaningful participation in community life and moves beyond the individual and organisation level to address the wider social, attitudinal and economic barriers to citizenship. Consequently, emphasis is placed on removing barriers to social integration and inclusion, such as stigma and lack of access to suitable housing, education, work and friendships” (in Higgins, 2008: 10). In the mental health field, these are areas in which social work practice is directed as it is understood that social issues such as housing, education, work, relationships and social capital have a strong bearing on causing or contributing to, a person’s mental distress.

5. Human Rights and Social Justice

Recovery, from my perspective as a social worker, is also heavily based on the notions of human rights and social justice, values which are fundamental to the practice of social work. I have worked with members of the Traveller community where the notion of recovery in mental health was linked to addressing the internalised oppression and structural discrimination of an entire community. I have worked with other minority ethnic communities where recovery in mental health was connected to a broader understanding of
Recovery: A Journey for all Disciplines

the role of spirituality and community in navigating one’s mental health difficulties. I have worked with people experiencing homelessness where recovery from mental distress was connected to having a safe and secure place to live. I have worked with people from minority ethnic communities where recovery in mental health was connected to the experience of racism or discrimination. A 2015 report further highlights the need for an approach to recovery that is underpinned by human rights and social justice. Through interviews with service users from diverse backgrounds it was clearly identified that “…the narrow focus of a traditional medical model of mental health, with its emphasis on the individual and personal pathology, significantly fails to address cultural and ethnic differences. More social approaches both encourage recognition of such issues and an anti-discriminatory approach and are themselves supported and advanced by this” (Beresford et al, 2015: 8).

How certain other work practices may need to change if there is to be a full adoption of a truly recovery-oriented approach.

There is much in common between social work practice, the service user experience and the concept of recovery (Sapouna et al, 2015). In parallel, it has been noted that it can be sometimes difficult for social workers to openly advocate for a truly social approach to mental distress within the context of the multi-disciplinary setting (Sapouna and Brosnan, 2015). It has also been noted that social work practice has, over the past decade, been impeded by managerial procedures, risk management and individualised work (Ferguson, 2010). In day-to-day practice, social workers in mental health do not tend to highlight how much they actually do that is recovery-focused and how much they actually do that is in line with progressive and modern mental health service provision. A lot of the time this is due to the tradition of social workers remaining “in the background” while working in partnership with people and communities. While this approach is positive in the sense that social workers tend to view people as the experts in their own lives, it can have a negative impact in the sense that many people and organisations i.e. the health service, other professionals and service users, may not actually know or understand the extensive, recovery-oriented work that is being carried out by social workers in mental health and how vital this work is
Recovery: A Journey for all Disciplines

to both the progression of a modern mental health service and to the users of the mental health service.

In acknowledging the existence of these barriers and of the cultural shift within the social and health system that is needed to change these facts, I am advocating for social workers in mental health to begin critiquing our work practices as they exist and to focus on enhancing and developing those practices which embrace a more explicitly social recovery-oriented approach. This is in line with the notion of reflective practice in social work and will contribute to the progressive development of the social work profession and of the service user experience of social work in the mental health service. My hope is that social workers will speak out about these practices without fear and begin to build alliances with other like-minded multi-disciplinary team members, service users, families and communities, in order that resources, support and time is given to embedding these vital practices in our every day work.

The opportunities for social work in leading these positive changes in the mental health service.

There are a number of ways in which social workers can lead in implementing positive changes in mental health, towards meaningful recovery-focused services. As professionals who are proficient in social policy and in systems-based thinking, social workers are well-placed to serve as the lead professionals in the roll-out and development of local initiatives which facilitate the services user, their family/carers and friends and the wider community towards recovery. As the Mental Health Commission (2005: a4) highlights, “The “recovery model” in mental health services emphasises…the development of services which facilitate the individual’s personal journey towards recovery” (in Higgins, 2008). As such, social workers around the country are heavily involved in recovery-focused peer-inclusive programmes such as the Eolas project. Social workers around the country have also been consistently involved in initiating and rolling-out local service user and family member forums which serve to build alliances and ensure the meaningful inclusion of the service user/care voice in how local mental health services are run. This is considered vital to
service users and carers as noted in Beresford et al (2015: 44), “Most service users who took part in the project felt that more discussions of social approaches in mental health and more challenges of existing medical approaches would be helpful. Participants then highlighted the importance of developing discussion, particularly among mental health service users and their organisations, about social approaches to mental health issues, policy and practice, as a basis for improving the life chances of mental health service users”.

Using core social work skills such as capacity building, empowerment, working in partnership and community needs assessments, social workers can foster true partnerships between services and people through the building of local programmes and initiatives that are co-produced. Social workers can take a lead in ensuring that the needs of carers and families are acknowledged and pro-actively included in the recovery journey, in their own right, the aim of this work being to ensure the sharing of experiences and building of alliances for not only the service user but the service users loved ones too. Work of this nature is already been undertaken in some areas of the country, for example, in the development of peer support groups for carers utilising a shared care approach with primary care based on the HSE Guidance document *Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services*.

Social workers can also take the lead in promoting an understanding of the social approaches to mental distress and its role in recovery-based services. As noted by Beresford, Nettle and Perring (2010), there is a strong wish for a broader understanding of mental distress amongst service users and for more social approaches within the mental health services. In this sense social workers can also take a lead on promoting an understanding of the structural barriers to service users’ recovery e.g. the lack of equitable access to safe and secure housing for all populations, the lack of equitable access to a living income for all populations, the discrimination and oppression faced by persons from diverse backgrounds who experience mental health difficulties. An example of this work in action is a grassroots, community-based mental health project for the Traveller community, initiated by social workers on a community mental health team, which focused on developing strong links between the local community mental health team and the local Traveller community,
the provision of culturally inclusive mental health services and the embedding of social approaches to mental health, in practice.

Finally, social workers can take a lead in ensuring the teams we work on are also looking at their own recovery as mental health professionals. This work is already been undertaken by mental health professionals around the country and this is why you will find social workers involved in national projects such as the *Enhancing Teamwork* project whose core function is to facilitate mental health teams to work more cohesively together in a meaningful way. Compassion and support for mental health workers as well as the users of the mental health services is a key component of the successful implementation of any recovery model.

In acknowledging that mental health is an issue for service users and practitioners we can promote the notion of equality between professionals in the mental health service and users of the service. This, in essence, is the key message for me as ultimately we are all people who deserve respect, support, compassion and understanding whatever our backgrounds and positions in the world.

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Closing Remarks

We are indeed in exciting times as we advance in the journey towards more recovery oriented mental health services. Our journey has been from the survivor and rights based movement which has been recognised in a number of significant international and national policy documents such as ‘A Vision For Change’, to where we are today with debates and initiatives such as ARI (Advancing Recovery in Ireland) aimed at bringing about the system and cultural change to make recovery a reality. However the ultimate challenge remains of how do we implement recovery in a way that will translate into more recovery oriented day-to-day interactions between service provider and service user? However, I believe we are also making progress in this regard; one can only be struck by how much we have moved in our understandings of the concept of recovery when you read through the reflection of our contributing authors above. Gone is the idea that recovery was something that happened after the medical interventions or that it was something for clinicians not to be concerned about. Today we have a much greater understanding of the multifactorial elements that contribute to mental wellness, or the lack of it, and indeed what contributes to meaningful personal recovery. The recognition that principles such as those embedded in the CHIME framework (Leamy et al 2011) are fundamental to recovery is very heartening to see. These can provide an approach which allows service providers to reframe their roles to a more recovery focused one, allowing them to support people with mental health issues, acting as co-facilitators of recovery with the person.

It is very encouraging to see the unanimity of our contributors in believing that their disciplines are compatible with and have something to offer recovery and indeed many state that recovery has something to offer them as well. However, all also agree that to be truly recovery oriented their disciplines are challenged to change. This change will involve how the various training schools train their practitioners. It will involve equipping their graduates with more than technical excellence, it will require engaging with people with lived mental health and recovery experience as well as allowing trainees and current
practitioners to embrace and integrate their own lived and holistic life experience into their practice. This may bring with it a realisation by practitioners that they too are on a recovery journey informed by the natural emotional rollercoaster of life events, stresses of work and frustrations of a service that does not deliver what it can. These experiences can give some insight into the similar emotional experiences of those who use services, and provide the environment for real recovery-inducing relationships to be created. Our contributors recognise and acknowledge the importance of lived mental health experience as an integral part of the service provided in a recovery focused mental health service. The benefits of having people with personal lived mental health experience in the service are twofold. Firstly, it gives a sense of hope at an individual level that recovery may be possible for people currently experiencing difficulties and secondly, it infuses recovery into the service and the team and acts as an agent of cultural change which helps enable service providers to become facilitators of recovery. The challenge we now task our strategists, policy makers and planners is to design structures that can support and sustain the inclusion of lived and recovery experience as an integral part of our service provision.

In such a service, as one of our contributors so eloquently stated, we will have ‘a person (Service User)-led’ ethos that will allow the team to work seamlessly but still utilising each disciplines unique clinical expertise as co facilitators to realise a common goal of personal recovery, as defined by the individual themselves. Fundamental to achieving this is the need to move towards ‘person-led’ recovery care planning which values the unique, individual and holistic nature of personal recovery. In such a context, as outlined in our foreword, difference is united by the same goal of personal recovery based on respectful and equitable relationships between all stakeholders. The emergence of recovery education in contexts such as ‘Recovery Colleges’ is an exciting development in mental health care provision. Based on adult education principles this type of approach can allow the relationship between stakeholders to be underpinned by equality.

Patricia Deegan in 2004 described recovery as “remembering who you are and using your strengths to become all that you are meant to be”. Is this not something that speaks philosophically to all humanity, in all situations and domains, not merely relating to those with mental health issues? It is very inspiring, in this context, to see professionals using the
Recovery lens to reflect on their practice and to re-acquaint themselves with their own core values. In doing so they found that the founding principles of their disciplines as defined from the likes of Pinel to Hildergard and Fransella are very compatible with the principles of recovery. As many of our contributors in this article have emphasised, all professionals need to engage in reflective practice to ensure that they are remaining faithful to those principles referenced in the literature above such as ‘inspiring hope’, ‘empathy’, ‘exquisite listening’ and ‘choice’. To do this we must all, professionals of all disciplines, service users, family members and supporters recognise our shared humanity as citizens of life. We must see the person underneath in each other and ourselves beyond the label! In this regard I hope the words below from Tony O Brien are truly prophetic ‘What I am asking is that all of us, at all times, look after every patient or client with exactly the same level of consideration that we would if they were our parent, sibling, partner or child. In other words, just as we would wish to be treated ourselves” - Tony O Brien, CEO HSE (2014).

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