

Recovery ...

what you should expect
from a good quality
mental health service



Mental Health Reform
Promoting Improved Mental Health Services

Recovery ... what you should expect from a good quality mental health service

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Introduction

A person who uses the Irish mental health services should be treated with empathy, respect and dignity by the mental health professionals they encounter on their way to recovery. Recovery is a very personal process. Ultimately, each individual will define what recovery means to them. Regardless of how somebody is feeling at any one particular time, the supports must be available to allow them to live their life to the fullest.

Mental Health Reform believes that realising the recovery ethos is central to achieving reform of the mental health services. During Mental Health Reform's consultation meetings in 2011 and 2012, people repeatedly expressed the need for a more humane service that listens to the service user. The simple request to be treated like a human being and to be listened to is not a costly transformation. More than anything it demands a change in the attitudes and behaviours of everyone involved in providing support for the person in mental distress, whether it is local primary care staff, mental health service staff, family carers or the wider community.

But what does such a transformation look like? What do we mean by a recovery-orientated service? And what changes are required by different stakeholders to realise this concept in practice? In this paper, Mental Health Reform describes our conception of the recovery ethos and how to bring this ethos to life in the delivery of mental health services. The paper is based on national and international policy, research and practice as well as the results of Mental Health Reform's public consultation undertaken during 2011 and 2012. We are grateful for the work that has been done by the Mental Health Commission and Prof. Agnes Higgins, both of whom have prepared sound advice on the recovery ethos for mental health services. Mental Health Reform supports the Mental Health Commission's Framework for a recovery-orientated service.¹

This is Mental Health Reform's roadmap for recovery-orientated services. We are committed to driving this vision forward.

What this paper covers:

1. What we mean by 'recovery'
2. Five key building blocks of a recovery approach
3. Implementing recovery-orientated mental health services
4. Social inclusion - the role of mental health services
5. Challenges for the future

¹ Higgins, A. (2008) *A Recovery Approach within the Irish Mental Health Services: A Framework for Development*, Dublin: Mental Health Commission.

1. Towards a shared understanding of recovery

The recovery principle set out in *A Vision for Change* reflects a substantial shift in conceptualising the role of mental health services. In her Foreword to *A Vision for Change*, Joyce O'Connor encapsulates the meaning of recovery for the purposes of the policy:

“A ‘recovery’ approach should inform every level of the service provision so service users learn to understand and cope with their mental health difficulties, build on their inherent strengths and resourcefulness, establish supportive networks, and pursue dreams and goals that are important to them and to which they are entitled as citizens.”²

O'Connor's description emphasises the active role that the person with a mental health condition plays in his/her own recovery in learning both about their mental health condition and how to manage it. She also highlights the importance of identifying the individual's strengths and resources, as contrasted with a focus on impairment and deficits. O'Connor includes a relational element to recovery – recovery is not likely to occur completely independently of all human relationships since it involves connecting with a network of supportive people and organisations. Finally, O'Connor draws the link between recovery and life goals; recovery cannot be assessed entirely on symptom reduction since it must reflect the extent to which an individual can fulfil their personal goals and aspirations.

Further on in the document, ‘recovery’ is defined in terms of its strong social inclusion component:

“One of the fundamental principles in this report is ‘recovery’, in the sense that individuals can reclaim their lives to their best extent and be involved in society – to be ‘socially included’.”³

This conception of recovery, adopted by the Expert Group and by successive governments as their mental health policy, poses a significant challenge to more traditionally-framed mental health services. From the start, *A Vision for Change* distinguishes between traditional, clinical recovery and this new recovery approach:

“While recovery does not necessarily imply a cure, it does suggest that the individual can live a productive and meaningful life despite vulnerabilities that may persist, equipped with the necessary self-understanding and resources to minimise relapse.”⁴

This distinction between the clinical and a more social and personal conception of recovery is an important one as it gets to the heart of the re-orientation necessary in the culture of mental

² *A Vision for Change: Report of the Expert Group on Mental Health Policy* (2006), Dublin: The Stationery Office, p.5.

³ *Ibid.*, p.41.

⁴ *Ibid.*, p.13.

health services. Traditionally, recovery from a 'mental illness' was conceived of primarily in terms of symptom remission – that is, a person would be considered to be recovered when their symptoms had reduced and they no longer fulfilled standard diagnostic criteria for a mental disorder. In the 1980s a conception of recovery developed that arose from the rehabilitation field and concerned maximising the individual's skills and work capability. This version of recovery is reflected in the 1984 mental health policy *Planning for the Future*. While it uses the term 'recover' and recognises that some individuals will re-gain life and work skills, it speaks in terms quite different from the version of recovery adopted in *A Vision for Change* because it continues to view recovery as primarily a function of the severity of 'illness', sees recovery as consisting of achievement of social and vocational skills, and considers that achievement of recovery depends on expert intervention. So *Planning for the Future* states:

“Rehabilitation in psychiatry is concerned with returning skills to a person who has had them impaired by mental illness ... The capacity to recover, even with the best rehabilitation available, depends mainly on the severity of the illness.”⁵

The recovery principle set out in *A Vision for Change* reflects a different conception, one in which symptom reduction and skill development may or may not play a part, but where the individual's own definition of their recovery sets the criteria. Higgins describes the role of clinical recovery within this new approach:

“Clinical phenomena or symptomatology are part of the person's intimate experience of being in the world, but the meaning that the person attaches to his/her own experience of illness is likely to have a measurable effect on his/her progress towards recovery. Therefore, the person's life story, fears, hopes, and unique social situation must be located at the heart of the therapeutic process (Barker and Buchanan-Barker 2005, Barker 2003, 2001).”⁶

A Vision for Change clearly endorses the personal/social recovery approach. This approach has since been further endorsed by the Mental Health Commission in its Framework for the recovery approach within mental health services. The Framework report states that:

“...what recovery means for a person is best defined by the individual within the context of their personal wishes, dreams, and capabilities.”⁷

Importantly, the Mental Health Commission's report also emphasises the social inclusion aspect of 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

⁵ Department of Health (1984) *The Psychiatric Services: Planning for the Future*, p.6.

⁶ Higgins, A. (2008), p.9.

⁷ *Ibid.*, p.8.

Recovery ... what you should expect from a good quality mental health service 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 (Department of Health and Children, 2006; Mental Health Commission, 2005).⁸

The roots of the recovery principle in the user/survivor movement

The personal and social conception of recovery has its roots in the service user/survivor movement. From the perspective of service users and survivors in the US, New Zealand and the UK, the recovery ethos reflects a desire to be liberated from the traditional approach to mental health care. Judi Chamberlin was an ex-service user and an early advocate for an alternative to the traditional psychiatric approach to mental distress, publishing her book *On Our Own* in 1977. She described her recovery journey in this way:

"...it was only when I became involved in the self-help and advocacy movement that I found what I had been looking for in the mental health system but never found there. That was people who were willing to listen, willing to accept my experiences, take me at face value, not start labelling my feelings and thoughts as symptoms, and that we can do this for one another, that it was a mutual activity - it was mutual support."⁹

Patricia Deegan, who has self-experience of a mental health condition as well as psychological expertise, spelled out how recovery involves a shift from patients being passive recipients of care to being active participants in the development of their own sense of self and purpose. She described how recovery is not necessarily about becoming 'cured' but rather about living beyond the disabling effects of the mental health condition. Deegan also described the importance of hope in her recovery – of those around her who maintained hope when she was in complete despair and of rekindling the flame of hope within herself.¹⁰ Importantly, Deegan highlighted how at the core of the recovery concept is the demand by people with disabilities to be treated as human beings, not as objects.¹¹

Mary O'Hagan, a survivor activist in New Zealand, sought to incorporate issues of social inclusion into the concept of recovery. She emphasised action to combat discrimination and the role of communities in supporting recovery.¹² Thus, though the New Zealand recovery competencies include recognition of the individual's inner resources and personal understandings of their condition, they also require staff to protect service users' rights, to understand discrimination and to actively support service users to connect with community

⁸ Ibid., p.10.

⁹ Chamberlin, J. (2008) 'Developing a recovery vision', downloaded 13/2/12 from <http://voices-of-recovery-schizophrenia.blogspot.com/2008/01/judi-chamberlin-developing-recovery.html>

¹⁰ Deegan, P.E. (1988) 'Recovery: the lived experience of rehabilitation', *Psychosocial Rehabilitation Journal* vol.11, issue 4, pp.11-19.

¹¹ Ibid., p.10.

¹² Mental Health Commission (New Zealand) (2001) *Recovery Competencies for New Zealand Mental Health Workers*, Wellington, NZ: Mental Health Commission.

Recovery ... what you should expect from a good quality mental health service supports.¹³ The New Zealand Blueprint also emphasises the shared responsibility between individuals and communities in recovery: individuals must take responsibility for their recovery, but “personal responsibility must be matched with social responsibility”, with communities and public agencies taking responsibility for supporting recovery.¹⁴

So too, people with self-experience of a mental health condition in Ireland have articulated a conception of recovery that emphasises personal and social aspects. The first study conducted in Ireland to gather perspectives of people with a mental health condition described recovery as a process of ‘reconnecting with life’ consisting of ‘reconnecting with self’, ‘reconnecting self with others’ and ‘reconnecting with self, others and time’.¹⁵ The study also identified hope as a key facilitator of recovery, while participants said having suitable medication was also important. Importantly, the study identified barriers to recovery, some of which relate to an overly-medicalised approach to treatment:

“Pessimism of diagnosis, medication side effects, being treated as a disease rather than a person, advanced years combined with socio-economic deprivation, long stays in in-patient units, and hostility and stigma in the broader community often created barriers to reconnecting with self, others and time.”¹⁶

Significantly, Irish service users described having to make a conscious decision to recover and having to ‘fight’ for their own recovery.¹⁷

A more recent study carried out by a peer researcher with members of GROW peer support groups also identified both personal and social elements to recovery. Watts developed a concept of recovery as ‘re-enchantment with life’, based on the narratives of 26 participants. This non-linear, recursive process involved three phases: ‘a place of terror’, ‘a time of healing’, and ‘an opportunity to become’. The ‘place of terror’ involves recognition that there are multiple causes for mental health difficulties, though the findings showed strong associations with having experienced trauma. The ‘time of healing’ involves realising the benefits of peer support groups that enable the individual to ‘bear witness’ to their experience in a ‘warm and welcoming environment’ as well as being encouraged to take risks and participate in community activities. Watts identified hope as a key factor in recovery: “Healing began with the awakening of positive feelings of hope, belonging and friendship...”¹⁸ Importantly, Watts argues that the individual themselves has primary responsibility for their own recovery.¹⁹

¹³ Ibid., p.7.

¹⁴ Mental Health Commission (New Zealand) (1998) *Blueprint for Mental Health Services in New Zealand: How Things Need to Be*, Wellington, NZ: Mental Health Commission, p.16.

¹⁵ Kartalova-O’Doherty, Y. and Tedstone Doherty, D. (2010) *Reconnecting with Life: personal experiences of recovering from mental health problems in Ireland*. HRB Research Series 8. Dublin: Health Research Board.

¹⁶ Kartalova-O’Doherty and Tedstone Doherty (2010), p.10.

¹⁷ Ibid., p.25.

¹⁸ Watts, M. (2012) *Recovery from ‘Mental Illness’ as a Re-Enchantment with Life: A narrative study*, Doctoral Thesis, Trinity College Dublin.

¹⁹ Ibid., p.199.

These varied writings on recovery illustrate that the recovery ethos as set out in *A Vision for Change* has its roots in the demands made by service user/survivor activists – demands for hope, demands to be treated as active, full human beings rather than as passive objects of care, demands for opportunities to live the way everyone else does, demands to be accepted and supported by communities.

Clinical recovery

The use of the term ‘recovery’ in mental health also developed from clinical perspectives. Higgins notes that the recovery concept arose after a series of studies and personal stories demonstrated that people could recover even from quite severe mental health difficulties.²⁰ The World Health Organisation’s (WHO) 2001 international study found that between 50-56% of people diagnosed with schizophrenia, a severe mental disorder, recovered.²¹ Another study carried out in Vermont found that only 11% of participants did not recover while 25% had fully recovered and 41% showed significant improvement.²² This challenged standard views current at that time that schizophrenia was a life-long, chronic condition. It led to a re-orientation of rehabilitation services in many countries away from maintenance care towards integration of service users into the community.

Mike Slade defines clinical recovery in terms of four features:

- “1. It is an outcome or a state, generally dichotomous
2. It is observable – in clinical parlance, it is objective, not subjective
3. It is rated by the expert clinician, not the patient
4. The definition of recovery is invariant across individuals.”²³

Clinical recovery refers to an individual’s mental state at a point in time, as measured by a clinician using standard criteria. Clinical recovery generally refers to a reduction in what are called symptoms of a mental health condition. It can be measured by assessing the extent to which an individual still meets a diagnosis for a mental disorder or the extent to which their psychosocial functioning fits in with standardised norms. Because it uses objective, standardised diagnostic or functional measures, a clinical definition of recovery can be used in research.

²⁰ Higgins, A. (2008).

²¹ Harrison G., Hopper, K., Craig, T. Laska, E., et al. (2001) ‘Recovery from Schizophrenia, a 15 and 25 year international follow up study’, *The British Journal of Psychiatry*, vol.178, pp. 506-517. et al. 2001 cited in Mental Health Commission (2005) *A Vision for a Recovery Model within Irish Mental Health Services: Discussion Paper*, Dublin: Mental Health Commission, p.8.

²² Harding, C.M., Brooks, G., Ashikage, T., Strauss, J.S. and Brier, A. (1987) ‘The Vermont longitudinal study of persons with severe mental illness II: long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia’, *American Journal of Psychiatry* 144:727-735, cited in Slade, M. (2009) *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals*, Cambridge: Cambridge University Press, pp.36-37.

²³ Slade, M. (2009), *Personal Recovery and Mental Illness: a guide for mental health professionals*, Cambridge: Cambridge University Press, p.140.

In contrast, service users and survivors describe personal recovery as an on-going process, not an outcome; it is more subjective than objective in that it is defined by the individual in their own terms and it is unique to each individual.

Slade argues that the personal recovery approach should be prioritised in mental health services and that clinical recovery should be viewed as a subset of personal recovery:

“... prioritising clinical recovery is helpful for many people in supporting their personal recovery, but inadequate for others and toxic for some.”²⁴

Similarly, Higgins emphasises the personal recovery approach, cautioning against the traditional ‘sidelin[ing] of individual human experience in favour of symptoms and clinical diagnosis.’²⁵

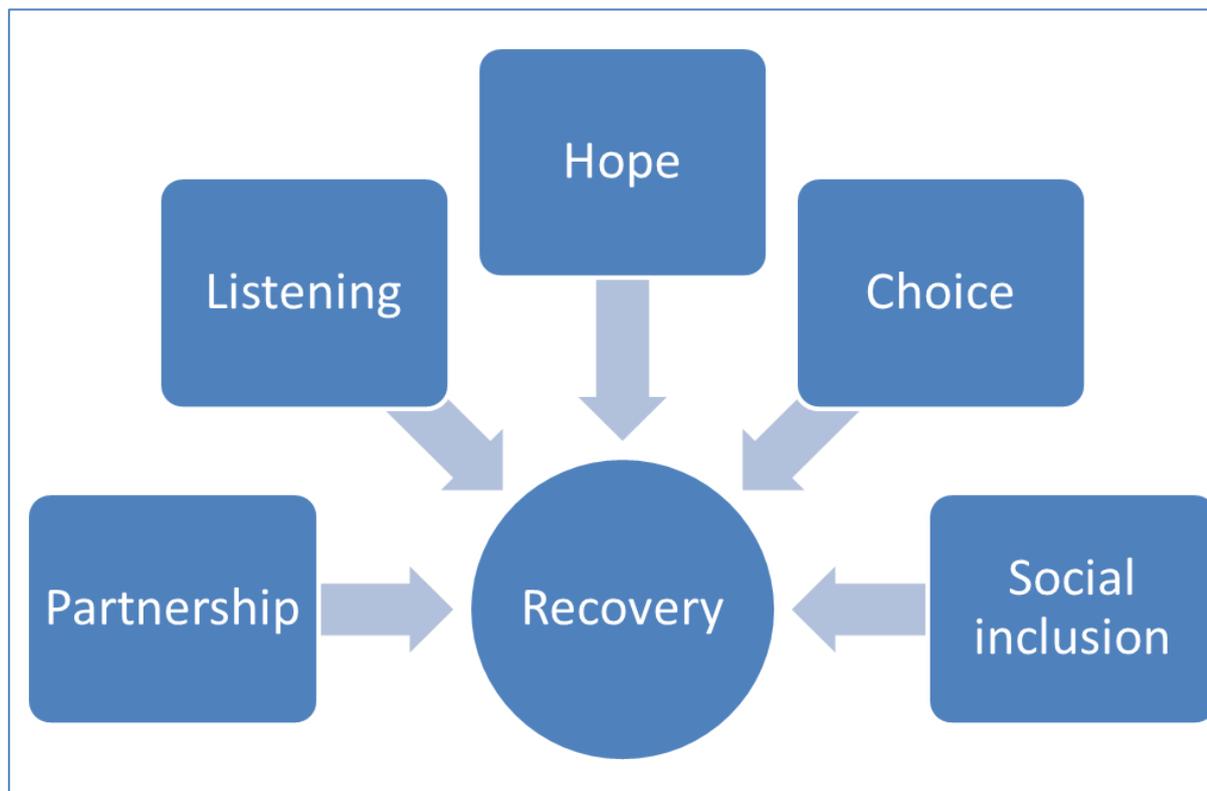
From the perspective of people with lived experience of a mental health condition, recovery is an individual process of discovering one’s own strengths, values, meaning and aspiration; a self-determined journey that can take place inside or outside the mental health system, through personal development, through partnership relationships with professionals, through peer support or through community support. It is a process of reconnecting with life that can happen for some with the continuation of symptoms while for others, a reduction in symptoms is important. In contrast, clinical recovery is an observable, objective state recognisable by a medical practitioner. While there are different definitions of clinical recovery, it generally includes the reduction or elimination of symptoms.

Clinical recovery can form a part of personal recovery but the two do not necessarily coincide. Some people will continue to have some symptoms while describing themselves as having recovered in terms of living a meaningful, fulfilling life. In order to fulfil the ‘recovery’ principle in *A Vision for Change*, mental health services need to respect the personal recovery perspective of each service user and adopt an approach to service delivery that supports both personal and social recovery. Recovery in this sense entails a democratising of psychiatry so that individuals and mental health professionals work together in partnership. Furthermore, a recovery ethos sets up a self-empowering agenda because it requires that users of services take ownership of and ultimate responsibility for their own wellbeing, within a supportive context. At its core, recovery also involves a ‘citizenship’ or ‘human rights’ agenda because it requires mental health services to recognise their role in supporting individuals to achieve their human rights and participate fully in society. In the next section, we describe five crucial components of a recovery-orientated mental health service.

²⁴ Ibid., p.43.

²⁵ Higgins, A. (2008), p.9.

2. Five key building blocks of a recovery-orientated approach



"People also must take responsibility for their own wellbeing and need to be supported in their own recovery."²⁶

Drawing on international and national literature as well as Mental Health Reform's public consultation meetings conducted in 2011 and 2012, Mental Health Reform identifies five core components of a recovery-orientated service.

Hope:

Mental health professionals must convey an expectation of recovery and must demonstrate belief in the individual's strengths and capacities. This has been a consistent demand of people with experience of mental health difficulties. They have described how the hopeful attitude of a key mental health worker or family member helped them to believe in their own capacity to recover. They identify this 'faith' as being key to their beginning to act to help themselves. Conveying hope means having a positive expectation about the future and expressing belief in the individual's capacity to lead a fulfilling life. It also includes focussing on the person's strengths rather than their deficits and building on their capacities rather than seeking to eliminate or cover over their incapacity.

"We need motivation."

²⁶ All quotes taken from Mental Health Reform's national consultation undertaken during 2011.

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"People must know that recovery is possible."

"We need to move from maintenance to recovery."

Listening:

Mental health professionals must listen to service users with attentiveness. This listening involves three aspects:

- 1) listening to the individual's personal understanding of their condition. It is important to acknowledge and respect the individual's own understanding of their experiences;
- 2) listening to the individual's aspirations and goals for their life. Only by understanding what the individual wants to get out of life can the mental health professional organise appropriate support. In this way, individual recovery planning is designed around the individual's life goals; and
- 3) listening to the individual's own knowledge about what helps them to recover and stay well. People living with a mental health condition develop an understanding of their condition over time. They often know from their own experience what works best for them in maintaining their mental health and what is ineffective. They know their experience of side effects from medications. They often know what triggers their mental distress. They know how they will define their own recovery. All of this self-knowledge is an important resource for developing recovery planning.

"We want to be seen as human beings."

Family members and friends also need to be listened to, with the permission of the individual concerned. Where permission is given, family members can provide useful information to mental health workers about what triggers the individual's mental distress, what the usual signs are when the individual is starting to deteriorate and what has helped the individual's recovery in the past.

Partnership:

At a one-to-one level, working with service users as equal partners in their own care is essential to redressing the traditional power imbalance between service users and professionals in the mental health services. A recovery-orientated approach demands equality between mental health staff and users of services. As described by Deegan (see above), the traditional approach whereby patients were passive recipients of professional expertise must give way to a process of reciprocal exchange between users of services and professionals.

Participation is also a core component of an approach based on human rights and is underpinned in the preamble of the Convention on the Rights of Persons with Disabilities. Participation by individuals in decisions affecting them is a crucial element of the right to health. Ireland has ratified the International Covenant on Economic, Social and Cultural Rights

which recognises the right of all persons to the highest attainable standard of physical and mental health (Article 12).

Recovery planning should involve a dialogue between service user, professional and carer (where relevant), in which meaningful communication about both the understanding of the 'problem' and the steps towards recovery takes place. Such dialogue between the service user and professionals needs to be an intrinsic part of clinical appointments. This partnership must also extend to planning, delivering and monitoring services, where people with experience of using services should be involved.

Family members and close friends can also play a valuable role in supporting recovery, where the individual concerned finds this acceptable. Carers are inevitably impacted by the mental health and social outcomes of their relative with a mental health condition. When family members have a good understanding of mental health conditions and ways of coping, they can play a positive role in supporting recovery. Family members also have their own needs for mental health and social support. Research conducted for the Mental Health Commission has also found that community mental health teams should provide support to family members, including on-going emotional support, respite care, assistance with accessing other types of services and education about mental health.²⁷

Wherever appropriate, services should reach out to family members/significant others as partners in providing support.

"These are people's lives. They need to be able to be in charge."

"Family members are crucial to recovery."

"Family should be seen, where helpful, as a resource."

"Families should be educated about mental health."

Choice:

Service users must be offered choices – of treatments and therapies, of who provides their care, of when and where supports are provided. In the absence of choices between alternative types of treatment, people are essentially denied their right to make decisions over their own mental health care.

If *A Vision for Change* was implemented, individuals would have the choice between hospital, crisis house or home-based treatment when they were in acute distress. Similarly, people seeking support should be able to choose between medication and talking therapies as a first option, and be able to discuss medication options with their consultant.

²⁷ Byrne, M. and Onyett, S. (2010) *Teamwork within Mental Health Services in Ireland: a resource paper*, Dublin: Mental Health Commission, p.14.

In order to make choices, everyone needs good quality, comprehensive and balanced information, including information about the risks and benefits of treatments. This has not always been provided, as evidenced by feedback from the National Service User Executive's 'Second Opinions' reports. The Mental Health Act requires some types of information to be provided to people who are involuntarily detained; Mental Health Reform has recommended that a similar provision be enacted for voluntary inpatients.

"We need talking therapies."

"We need education and a holistic approach."

Social inclusion:

Mental health services have an important role to play in supporting people with a mental health difficulty to participate in their local community, have social relationships and engage in meaningful activities including education and employment.²⁸ This includes helping those at risk of homelessness to secure housing. It also means community mental health staff developing relationships with local community services such as training and education, employment support and housing providers. In this way, community mental health teams become a bridge between the mental health services and mainstream community supports, services and activities. Mental health staff have a role to play in supporting people to claim their rights and entitlements. Equally, local staff of public and community services must play their part in supporting the recovery of people with a mental health difficulty.

"People need to be more inclusive, people must take responsibility for each other, we all need to be part of this."

"We need to find ways of increasing self-confidence. Increase productivity in all areas of life, not just in jobs. Get people involved in the community, in hobbies, etc."

"Employment gives people a reason to get up in the morning."

Summary of a shared understanding of recovery

The recovery principle encompasses five key aspects of mental health service delivery: hope, listening, partnership, choice and social inclusion. Hope is essential for any individual's recovery – mental health staff and family members who reflect a hopeful attitude can have a big influence on the individual's self-confidence and motivation. Mental health professionals need to listen to users of services and families as a starting point for working in partnership. Without choices, the right to autonomy at the heart of the recovery ethos would be empty. Users of services need to be able to make choices in terms of the types of treatment or support they use as well as with whom, when and where. Social inclusion is also an essential component of a

²⁸ Repper, J. and Perkins, R. (2003) *Social Inclusion and Recovery*, London: Ballière Tindall.

recovery approach; mental health services have a role to play in supporting individuals to connect with their own community and fulfil their employment, education and life goals.

Mental Health Reform's definition of recovery complements the conceptual work undertaken by Prof. Agnes Higgins for the Mental Health Commission. The Commission's Framework for development of a recovery approach in mental health services identifies optimism about recovery, valuing the individual's development of meaning about their experience and respect for the individual's self-expertise as principles of a recovery approach. The Framework identifies the importance of involving users of services in their own care and of social inclusion as a goal of mental health service delivery.²⁹ There is clear overlap between the Mental Health Commission's Framework and Mental Health Reforms' definition of recovery. Our version of recovery reflects the consultation that we undertook with users of services and family members as well as the international literature, and while the exact components may be named somewhat differently, the essential message of a respectful, empowering and hopeful response to individuals in mental distress is consistent.

3. The Convention on the Rights of Persons with Disabilities: A buttress for the recovery ethos

The recovery ethos as defined by users/survivors of mental health services has always included a strong citizenship agenda and emphasis on human rights. Survivor activist Mary O'Hagan commented in 2001 that the mental health service user movement's "underlying philosophy of human rights and self-determination" was a key source of the recovery ethos.³⁰ This link between the recovery ethos and human rights has also been recognised in Irish policy. 'Citizenship' is one of the core principles of *A Vision for Change*, encompassing respect for human rights. The Mental Health Commission's Framework document on recovery asserted that the recovery ethos "puts the spotlight on issues of human rights, citizenship, advocacy and service user partnerships with professionals ..."³¹

The most recent UN statement on the rights of people with a mental health condition is set out in the UN Convention on the Rights of Persons with Disabilities (CRPD). The CRPD does not set out new human rights but it does articulate human rights in a new way for people with disabilities, including people with a mental health condition.

One over-arching parallel between human rights and the recovery ethos is a shift away from focussing on the individual's deficits. The core philosophy underpinning the CRPD is a 'social model of disability' that moves away from focussing on an individual's impairment towards paying attention to the way that society disables people who have impairments by creating structural and cultural barriers.

²⁹ Higgins, A. (2008).

³⁰ O'Hagan 2001, p.2.

³¹ Higgins 2008, p.9.

The recovery ethos makes a similar shift away from a focus on the individual's clinical symptoms and towards recovery as the development of a meaningful life of full citizenship. Both perspectives arose from activism by people with disabilities/mental health conditions who challenged the traditional ways of framing their situation. Like the social model of disability, the recovery ethos stems in part from people with a mental health condition seeking more affirmative responses to their experiences, rather than the traditionally negative approach of framing these as 'deficits'. One of the key messages in the CRPD is that of valuing diversity:

“Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity” (Article 3(d)).

A further example of the way in which the CRPD seeks to remove barriers to recovery and underpin a change in society's approach to those with mental health conditions can be found in Article 5, which calls for equality and non-discrimination and requires states to provide reasonable accommodation to ensure that this is achieved.

The CRPD's affirmation of the social model of disability thus lends support to those aspects of the recovery ethos that affirm the positive value of individuals with a mental health condition as full citizens. The human rights based approach reflected in the CRPD views people with disabilities as the subjects of rights or rights holders rather than as the passive recipients of benefits, while at the same time placing an obligation on the State to respect, protect and fulfil the human rights of people with disabilities.

Specific rights set out in the CRPD also have direct relevance to the recovery ethos. Most obviously, Article 26 provides a specific right to rehabilitation services. The article sets out that governments must enable individuals with a disability to attain and maintain maximum independence, full physical, mental, social and vocational ability and full inclusion and participation in all aspects of life. This article clearly supports the strengths-based, community-orientated approach entailed by the recovery ethos. It also affirms the role of peer support by including this among the measures that governments are required to implement.

Articles 3, 12 and 17 of the CRPD affirm individuals' right to autonomy and to have their will and preferences respected in decisions about all aspects of their life. These articles are in accordance with the recovery ethos' emphasis on listening to the voice of mental health service users about their preferences for treatments and supports and giving them effective choice over such decisions. Article 12 specifically provides that “persons with disabilities have the right to recognition everywhere as persons before the law.” This is echoed in the Preamble to the Convention which recognises “the importance for persons with disabilities of their individual autonomy and independence including the freedom to make their own choices” and that “persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them.” The paradigm shift reflected in Article 12 necessitates a move from substitute to supported decision-making and recognises that a person's autonomy can be expressed in different ways.

Several other articles in the CRPD support social inclusion, including Article 2 that underscores the principle of non-discrimination and Article 19 that articulates individuals' right to live independently in housing of their choosing with community support. Other articles affirm the rights of individuals with disabilities to education, employment opportunities, housing and adequate income.

As previously mentioned, the principle of partnership that entails a process of co-decision-making towards recovery is also supported under human rights law. Participation is a core component of an approach based on human rights and is included in the Preamble of the CRPD. Participation by individuals in decisions affecting them is also a crucial element of the right to health as set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights, to which Ireland is a signatory.

It is evident that human rights law in general and the CRPD in particular can be a valuable buttress to the recovery ethos. The CRPD provides an internationally-recognised legal standard that supports most of the components of the recovery ethos. The Irish Government's intention to ratify the CRPD and to take steps to ensure its fulfilment in Ireland will provide further impetus to implementing the recovery ethos within the HSE's mental health services and within other Government agencies covering education, employment, housing and social welfare.

4. Implementing the recovery ethos in service delivery

Bringing the concept of recovery from an idea to reality within the mental health services requires a dedicated programme of implementation. This programme entails both structural and cultural change. It is about visibly demonstrating the values and having adequate laws, funding, staffing and facilities, but it also requires working from a recovery 'mind-set' and adopting attitudes of hope, respect and empathy towards people with a mental health condition and their families and friends. Developing a service where people feel heard, consistently supported by trusted professionals and respected as partners in choosing appropriate therapeutic options does not have to be costly. In this section we outline the cultural and structural change that needs to happen to develop recovery-orientated mental health services in Ireland. We also identify a number of key practices that demonstrate a recovery approach.

Cultural change

The recovery approach involves incorporating a new set of values into mental health care delivery; it requires 'values-based practice' alongside 'evidence-based practice'.

In order to instil the values of hope, respect, empathy, equality and human rights within the mental health services, all service providers need to implement a dedicated programme of cultural change. This will require national and local leadership, with those who hold senior positions both modelling the desired attitudes and behaviours and also demanding those attitudes and behaviours from all staff in the organisation. It also requires a dedicated process

of reflection among staff. Staff need regular time to explore how recovery values impact on their practice and what challenges there are in trying to fulfil these values within a mental health workplace. It is vital to create safe spaces where staff can discuss their concerns, explore their underlying values and mindset and develop a shared understanding about the values and mindset that accord with the recovery ethos.

Management also needs to hold staff accountable for demonstrating recovery values. At the earliest opportunity, recruitment should incorporate the values of hope, respect, empathy, equality and human rights into the person specifications for all mental health service staff. Recruitment panels should be aware of these values and assess candidates' aptitudes and skills on the basis of these values. On an on-going basis, supervisors should incorporate performance of these values as part of staff supervision. At a national level, performance monitoring needs to reflect achievement of the recovery ethos in key performance indicators.

One method of developing a shared understanding between people with a mental health condition, family members and others in the community is through creating spaces where dialogue between diverse perspectives can occur. The 'open dialogue' approach is currently being run in Ireland through the Mental Health Trialogue Network. A trialogue is described by the network as:

“a neutral space where communities can gather to develop their understanding of mental health issues, the challenges of maintaining mental health and to transform thinking on developing better services and healthy communities.” (see www.trialogue.co).

Another approach is through the development of consumer panels, where users of services and family members/significant others meet to discuss their experience of the services and then meet with local management to raise their concerns. Consumer panels have been in place in some parts of the country for several years and are now expanding. Both methods improve communication between people with a mental health condition, family members/significant others and service providers.

Other key steps in implementing recovery-orientated services are:

- Developing a service mission statement that reflects recovery values
- Developing service policies that foster hope, listening, partnership and choice
- Developing service procedures that operationalize recovery values, such as positive risk management policies that promote self-determination
- Measuring achievement of service users' goals, social inclusion and discharge from services
- Providing facilities that are open, pleasant and that do not separate out staff from service user areas
- Supporting service users to link in with local community services and supports
- Training staff in how to assess capabilities, identify and plan action towards recovery goals and support the development of a meaningful life

- Employing people with experience of a mental health condition in the delivery of services, including peer support workers and peer advocates, and reporting on the number of peer workers employed in the mental health services
- Supporting people with a mental health condition to challenge prejudice and discrimination in services and the wider community
- Ensuring that individuals' human rights are protected, respected and fulfilled

(Based on Farkas, Gagne, Anthony and Chamberlin (2005), Higgins (2008) and Slade (2009))

From therapeutic to educational services

The Recovery College (or Recovery Education Centre) is an initiative that aims to re-orientate a mental health service away from a traditional therapeutic approach towards an education-focussed mode of service provision. As described by Perkins, et al. for the Centre for Mental Health, the Recovery College re-frames the supports provided for an individual's recovery into an educational journey, in which the individual participates in 'courses' of their choosing that facilitate their recovery. A key principle of the Recovery College is co-production – people with self-experience of a mental health condition and mental health professionals work together at every level of the College's planning, delivery and evaluation. Therapists are called 'tutors' and take on co-teaching rather than expert roles. Courses are open to everyone in the community including people with a mental health condition, carers and family members, mental health staff and staff of other community agencies. Course content may include information about mental health and treatment options, self-management skills, life skills and caring skills.³² This initiative is being piloted in the Castlebar mental health service, which is currently establishing a Recovery College.

From 'care' to 'recovery' planning

One practice that can permeate an entire mental health service is the development of individual planning that takes a recovery approach. The Independent Monitoring Group for *A Vision for Change* has stated that promoting best practice in care planning is one of the critical factors in shifting services towards recovery-focussed care.³³ While the individual's involvement in planning their own treatment is increasing in Ireland, many service users are not adequately involved in making decisions about their own care. De Burca, Armstrong and Brosnan found that of 100 service users asked, only 42% were aware that they had a care plan.³⁴ On the positive side, only 8% of participants disagreed that they had been involved in making decisions about their care plan, but worryingly, 34% said they had not been involved in choosing their

³² Perkins, R., Repper, J., Rinaldi, M. and Brown, H. (2012) *Briefing: Implementing Recovery through Organisational Change: 1. Recovery Colleges*, Centre for Mental Health available at http://www.centreformentalhealth.org.uk/pdfs/Recovery_Colleges.pdf

³³ Independent Monitoring Group (2012) *Sixth Annual Report on Implementation: 2011* available at www.dohc.ie/publications

³⁴ De Burca, S., Armstrong, C. and Brosnan, P. (2010) *Community Mental Health Teams: Determinants of Effectiveness in an Irish Context*, Limerick: Health Systems Research Centre, p. 160.

treatment and 20% said they had no say in the decision about their medication. The National Service User Executive has also found that service users and family members are not receiving enough information.³⁵

The Mental Health Commission has published guidance on Individual Care Planning (ICP) that builds on the regulatory requirement for an individual care plan for all individuals in approved centres. The guidance is also intended to inform practice in community-based mental health services, though there is no legal requirement for individual care plans in community settings.

The Commission's Guidance document is intended to support a recovery ethos. The Commission advises that a care plan should reflect the needs and wishes of the individual. It should also address both immediate 'care and safety' concerns and longer-term recovery.³⁶ The Commission also advises that service users be central to the care planning process:

"A prerequisite to care planning is the fundamental component of service user involvement. The service user must be a partner in his/her own mental health care. The care plan belongs to the person accessing services. If services are to deliver a recovery-oriented service, practice should always be directed towards facilitation or resumption of the person's own decision making in all aspects of his/her life."³⁷

This strong statement on service user involvement underpins all of the MHC's guidance on care planning.

One area where the Commission's guidance is unclear concerns the difference between clinical and personal/social recovery. Whereas Slade proposes that personal recovery should take precedence over clinical recovery, the Commission's ICP Guidance document sets up a split between 'treatment goals' and 'recovery goals', making the individual responsible for recovery goals while the staff are responsible only for treatment goals. While it is useful for professionals to be able to distinguish their role in facilitating recovery as contrasted with the individual's and family members' roles, the advice that staff are responsible only for treatment goals seems at odds with the recovery ethos and could militate against professionals playing their part in facilitating personal recovery and social inclusion.

The Mental Health Commission does not endorse any particular template for Individual Care Planning. The Commission emphasises that the documentation for ICP is less important than ensuring good practice is done in the process of care planning. However, there are some planning tools that have been developed in collaboration with users of services that reflect the recovery ethos.

³⁵ National Service User Executive (2011) Second Opinions 2010 available at <http://www.nsue.ie/documents/>

³⁶ Mental Health Commission (2012) Guidance Document on Individual Care Planning Mental Health Services, Dublin: Mental Health Commission, p.9.

³⁷ Ibid., p.15.

The Recovery Star is a one-to-one planning tool that has been developed in the UK. In 2009 it was endorsed by the UK Government to be implemented across mental health services in England and it has since been validated as a measurement of recovery.³⁸ The Recovery Star provides both a template for one-to-one interaction between staff and users of services and a measure that can demonstrate an organisation's achievement of recovery-orientated outcomes for their users of services. The Recovery Star covers progress in self-management of mental and physical well-being, personal attitudes, skills, work and social relationships. It is entirely personalised and, as much as possible, the individual assesses for themselves where they are in each of these life areas and determines which areas they want to work on. While differences of view between service user and professional are allowed within the Recovery Star process, the key worker is encouraged to make these differences a focus of engagement with the user. The Recovery Star guidance for key workers also advises that a difference of view can be overcome through the keyworker gaining a better understanding of the service user's perspective and even potentially changing the key worker's view, as well as the other way around.³⁹

In terms of progress on mental health, the Recovery Star focuses on the individual's capacity to manage their own mental health more than on the presence or absence of symptoms. It also builds the person's ownership of their recovery plan and thus strongly underpins a partnership approach to care planning. Many of the resources are available free from the Mental Health Providers Forum (see <http://www.mhpf.org.uk/programmes-and-projects/mental-health-and-recovery/recovery-star>). Mental Health Reform is aware of a few services across the country that have been using the Recovery Star and would encourage others to adopt this or a similar approach.

Part of recovery planning concerns assessing the risk that individuals will experience self-harm or harm others. The HSE has produced a guide to risk management in the mental health services that reflects the recovery ethos. The HSE advises that the recovery ethos and a partnership approach between service users, carers, health professionals and others should underpin risk assessment and management. The guidance also identifies that "risk management must be built on recognition of the service user's strengths and should emphasise recovery."⁴⁰ This guidance represents a positive step in instilling the positive risk-taking culture that should become the norm within mental health services. However, it is important that the implementation of this guidance is regularly assessed across the HSE's mental health services.

Another aspect of recovery-orientated planning is to adopt a different approach to the use of medication. Traditionally, medication has been used to ameliorate the distressing mental and emotional experiences of mental health difficulties. The focus has been on applying medication

³⁸ Dickens, G., Weleminsky, J., Onifade, Y. and Sugarman, P. (2012) 'Recovery star: validating user recovery', *The Psychiatrist* 36:45-50.

³⁹ Mental Health Providers Forum (2009) Mental Health Recovery Star: Organisational Guide available at www.mhpf.org.uk, p.10.

⁴⁰ HSE (undated) Guidance Document: Risk Management in Mental Health Services, available at <http://www.hse.ie/eng/services/publications/services/mentalhealth/riskmanagementinmentalhealth.pdf>

to the point where symptoms are reduced. Often this has meant maintaining medication use indefinitely as a means of keeping symptoms at bay. However, the use of medication over the long-term is not without consequences. For example Rufus May (a clinical psychologist with personal experience of psychosis) has pointed out how the use of medication over the long-term can be disabling. Even the so-called 'newer', atypical antipsychotics can have serious side effects such as weight gain that can impact on an individual's self-confidence and self-esteem (as well as their health), while he reports that "emotional and generalized cognitive blunting, increased sleep and lethargy are common." May seeks an approach to medication that recognises the risks of disability caused by medication alongside the risks of psychotic experiences.⁴¹

A recovery-orientated approach to medication starts from a balanced, open discussion between service user and psychiatrist about the risks and benefits of taking medication. In such an approach, the professional will respect the individual's values and choices with regard to medication. Where medication is used, prescribing would take account of the individual's social goals, e.g. to be able to engage in work or education, to be able to provide parenting for a child, etc. Such an approach would seek to ensure that medication does not interfere with the person's ability to fulfil their personal goals in as much as this is possible. A recovery-orientated approach to medication would also provide professional support to reduce or withdraw from medication, where this is the expressed wish of the service user.

"The person who is unwell is the expert themselves. They need to have control over their own condition. I know a woman who had numerous suicide attempts but said to her doctor she wanted to try an alternative. Her doctor supported her to do that. She did the WRAP programme and is now medication free."

Peer support, peer advocacy and peer workers

Bringing people with mental health difficulties into contact with those who are in recovery is an effective way of fostering hope. Patricia Deegan described this process:

"The third recommendation for creating [rehabilitation] programs that enhance recovery involves recognition of the gift that disabled people have to give to each other. This gift is their hope, strength and experience as lived in the recovery process. In this sense, disabled persons can become role models for each other. During that dark night of anguish and despair when disabled persons live without hope, the presence of other recovering persons can challenge that despair through example. It becomes very difficult to continue to convince oneself that there is no hope when one is surrounded by other equally disabled persons who are making strides in their recovery!... Hope is contagious and that is why it is so important to hire disabled people in rehabilitation programs."⁴²

⁴¹ May, R. 'Understanding psychotic experiences and working towards recovery' available at http://rufusmay.com/index.php?option=com_content&task=view&id=30&Itemid=33

⁴² Deegan, P.E. (1988).

A growing evidence base points to the effectiveness of peer involvement in support. A report produced by the Canadian Mental Health Association found that peer support is associated with:

- Reductions in hospitalizations for mental health problems
- Reductions in 'symptom' distress
- Improvements in social support
- Improvements in people's quality of life⁴³

A report prepared for the Canadian Mental Health Commission concluded that peer support is effective, with strong evidence for self-help groups but growing positive evidence for other types of peer initiative such as consumer-run organisations and peer support workers in mainstream settings. The authors based their conclusion on an international literature review and engagement with more than 820 people with a mental health condition:

"We found that the development of personal resourcefulness and self-belief, which is the foundation of peer support, can not only improve people's lives but can also reduce the use of formal mental health, medical and social services."⁴⁴

In Ireland the involvement of peers in the delivery of services is beginning to gather momentum. Ireland has progressed well in the provision of peer advocacy since the establishment of the Irish Advocacy Network in 1999 and currently peer advocates are available in inpatient units throughout the country. Many advocates have also become involved with management, participating regularly in local management teams. Services in Ireland are also beginning to employ peer support workers. The mental health service in Castlebar is employing a number of peer support workers as part of its project to implement the recovery ethos using the Implementing Recovery – Organisational Change (ImROC) methodology. A peer support worker is also employed in the West Cork mental health service.

The Clubhouse model is also well-established in Ireland, having been pioneered by EVE Ltd. (a HSE service). Clubhouse is a recovery-orientated and community-based service founded on the belief that recovery is possible and that people who experience mental health difficulties can and do lead fulfilling lives in their communities. As a member-led service, it actively promotes opportunities to build long-term relationships and access employment, education, housing and social activities in fulfilment of the social inclusion aspect of recovery.

⁴³ Canadian Mental Health Association, Ontario, Centre for Addiction and Mental Health, Ontario Federation of Community Mental Health and Addiction Programs, & Ontario Peer Development Initiative (2005) *Consumer/Survivor Initiatives: Impact, outcome, and effectiveness*, Toronto, ON: Ontario Federation of Community Mental Health and Addiction Programs.

⁴⁴ O'Hagan, M., Cyr, C., McKee, H. and Priest, R. (2010) *Making the Case for Peer Support: Report to the Mental Health Commission of Canada: Mental Health Peer Support Project Committee*, available at <http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Peer%20Support/Service%20Systems%20AC%20-%20Peer%20support%20report%20EN.pdf>, p.10.

The Clubhouse model operates from an empowerment ethos that encourages members to take ownership of their Clubhouse by adopting meaningful roles in its day-to-day operations. This facilitates a strong culture of peer support that has the potential to promote member self-esteem, control and enhanced quality of life. At its core the Clubhouse achieves a re-alignment of power and personal responsibility, which can prove challenging for members, staff and providers but ultimately builds a recovery community for all.

Peer support groups have also developed in Ireland. GROW Ireland operates a network of 130 peer support groups across the country. These groups adopt a 12-step approach to peer support for mental health recovery. GROW considers that its principal strength is the support members give each other from their own experience in matters to do with mental health.⁴⁵ Shine provides peer support groups for people with psychosis and related mental health issues. These Phrenz Groups are a “nationwide mutual self-help network which aim to empower people with schizophrenia and related illnesses.”⁴⁶ These organisations and others provide a vital and effective community-based support that is essential to the implementation of the recovery ethos in Irish mental health services.

The development of other peer-run services has been much slower, with few peer-run day services. The Gateway Project in Rathmines is one of a handful of peer-run drop-in centres nationwide that has been led by people with self-experience of a mental health condition. The Solas drop-in centre in Monaghan is another example of a user-run social centre for people who have used mental health services.

Watering the field – Structural change to incentivise recovery

With the best intentions, it will not be possible to implement a recovery ethos in services if the structural conditions of the service are not favourable. Staff must operate in an environment that facilitates recovery, including having a legal framework that promotes choice, autonomy, de-institutionalisation and positive risk taking, adequate staffing of multidisciplinary teams and appropriate, modern facilities.

Legislative reform

Mental Health Reform has advocated for changes to Ireland’s mental health law. Mental health legislation in Ireland needs to be reformed so that it fully protects individuals’ human rights. Currently the rights of voluntary users of services are not provided for in mental health legislation. This needs to change so that voluntary users of services have the right to be informed about their mental health diagnosis and treatment, to make choices about their care and to leave mental health inpatient facilities if they so desire. The law does not adequately protect individuals who lack the capacity to make their own decisions, who are currently treated as voluntary patients. This also needs to change urgently so that people who have difficulty making decisions are provided with adequate support to maximise their capacity, and have their rights protected in the process of decision-making. The protection for involuntary

⁴⁵ See www.grow.ie

⁴⁶ See www.shineonline.ie

users of services also needs to be strengthened so that they have rights to make decisions about their mental health treatment.

Specifically, protection for users of inpatient services needs to be strengthened so that:

- The human rights of so-called 'voluntary' but incapacitated service users are protected
- All service users, both inpatient and outpatient, have a direct route to an independent body to make a complaint about the mental health services
- Voluntary service users are given the right to information
- Voluntary service users are protected from coercion
- Voluntary and involuntary service users' right to make decisions about their treatment are protected
- Voluntary and involuntary service users have a statutory right to advocacy
- Seclusion, physical and mechanical restraint are reduced
- The use of chemical restraint is regulated
- Every service user has an individual care and recovery plan developed with their input
- The role of families is recognised in the law so that they receive information and support
- Service users are adequately protected from abuse

These changes to mental health law are necessary for implementing the recovery ethos; without such rights under law it is impossible to fulfil the principles of choice and partnership which are essential to the recovery approach.

A few words about resources

Without adequate resources, fulfilment of the vision set out in *A Vision for Change* is not possible. Mental health services are delivered by people and so the bulk of costs in the mental health services relate to staff costs. This is one reason why mental health services have fared poorly in the allocation of overall health resources in recent years.

Recovery-orientated services require, in the first instance, multi-disciplinary staffing that can provide not only medical but also social and psychological support to individuals. The community mental health team must be able to provide a range of therapies to offer choices to service users. And there must be adequate staffing levels so that staff have the capacity to allow time for listening to service users and families/significant others.

The type of effective team-working that facilitates recovery also requires having a multi-disciplinary team. In Ireland as recently as 2010 researchers found that "the traditional medical model is still dominant with the psychiatrist as clinical team leader."⁴⁷ Community teams in Ireland are poorly developed, with 80% of teams lacking a full complement of disciplines.⁴⁸ This

⁴⁷ De Burca, et al., Op. Cit., p. 141.

⁴⁸ Ibid., p. 98.

imbalance in staffing has resulted in a continuation of a 'medicalised model' of care provided predominantly by the disciplines of psychiatry and nursing, with relatively low levels of input from psychologists, social workers and occupational therapists.⁴⁹

The multidisciplinary staff currently being appointed to the mental health services will significantly improve the range of input into teams, though it is unclear whether the resulting staff level will be adequate. So too the HSE's teamworking initiative is a welcome step towards embedding effective multidisciplinary practice within services.

Accountability for implementation

Slade argues that recovery-orientated services must develop an 'outcome evaluation strategy' to assess their progress on fulfilling the recovery ethos.⁵⁰ Services must be able to regularly evaluate their own recovery practice and visibly demonstrate to stakeholders that they are recovery-orientated. Slade suggests that this evaluation should cover two dimensions: objective achievement of quality of life indicators and subjective progress towards the individual's personal goals.⁵¹

In Ireland, the Recovery Context Inventory (RCI) has been developed by EVE, a programme in the HSE, for the purposes of tracking individual progress towards recovery goals and for service-wide planning. The RCI is a web-based mental health recovery profiling and outcome measurement tool. It has been rigorously developed over the past seven years in Ireland and the UK by EVE. The construction of the RCI has been characterised by the strong involvement of key stakeholders and the use of best practice methodologies for scale development.

The tool allows people to assess the presence of contextual factors in their lives that they believe are important to their wellbeing and recovery under the main headings of 'personal supports' and 'service supports'. In this way the structure of the RCI facilitates a personal evaluation of a broad range of factors, including mental health services, that impact upon the recovery process. The RCI has a unique rating system that is sensitive to the highly personal and staged nature of the recovery process. The producers of the RCI hope that for service users, the experience of taking part in the RCI will support an increase in self-awareness and reflection and promote self-determination through personal recovery action planning.

For the purposes of service planning using the RCI, work is currently underway to produce an aggregated report facility that will show the perceived recovery priorities and status of service users. This 'real time' facility can support the planning and delivery of targeted, evidence-based and person-centred mental health services.

While the validity of the RCI has yet to be confirmed, a Bamford Review in Northern Ireland of patient outcome measures provisionally recommended that the RCI be considered for use there as a measure of the recovery orientation of a service.⁵² The RCI will be introduced into six

⁴⁹ Ibid., p. 101.

⁵⁰ Slade, op. cit., pp.191-196.

⁵¹ Ibid., p.196.

⁵² Donnelly, M., Scott, D., Mc Gilloway, S., O'Neill, T., Williams, J., & Slade, M. (2011)

mental health services in Ireland as part of the Genio-funded Advancing Recovery in Ireland (ARI) project. During this phase evaluation of the measure will continue, with a focus on critical implementation, process and outcome indicators for both service users and participating mental health services. To complement the use of the RCI, an RCI Recovery Planning Workbook and a Facilitator Training Programme manual have been developed.

Summary of implementing the recovery ethos in service delivery

Implementing the recovery ethos will require both cultural and structural change in the mental health services. The HSE needs to implement a dedicated programme of cultural change so that the values of hope, respect, empathy, equality and human rights are embedded within mental health services. This programme must be driven by leadership from the top and involve all staff. It must initiate a specific, national culture change project and embed recovery values into on-going accountability procedures. The recovery ethos must be embedded into each service's mission and values, policies and procedures, recruitment and evaluation. A national system to monitor and evaluate recovery orientation is required to ensure that services fulfil the recovery ethos.

Practices that reflect the recovery ethos include recovery-orientated individual planning with strong involvement of the individual themselves, the use of individual planning tools designed around recovery such as the Recovery Star, risk management that reflects the recovery ethos, the employment of people with self-experience of a mental health condition in valued roles within services and the development of peer-run services. The 'Recovery College' is a new mode of service delivery that aims to re-frame services as centres of education rather than the traditional day centre.

In Ireland the Advancing Recovery in Ireland (ARI) project funded by Genio has the potential to further build momentum for this culture change by supporting six sites to implement the ImROC methodology already begun in Castlebar. It will be important that this initiative is evaluated for its effectiveness within an Irish context. If successful, the ARI project could provide a basis for the type of system-wide programme of culture change required throughout the mental health services. Much depends on whether the key principles of hope, listening, partnership, choice and social inclusion are fulfilled through these projects.

Implementing the recovery ethos also requires structural change. Irish law needs to be strengthened to protect the rights of voluntary, involuntary and incapacitated users of services. In this way, the law can better incentivise the principle of autonomy that is at the heart of the recovery ethos. Fulfilling the recovery ethos also requires adequate resources. Without community mental health teams that have multi-disciplinary staff, and adequate resourcing of peer initiatives, it will not be possible to offer the type of good quality, holistic service that people deserve.

5. Social inclusion and the role of non-health agencies in supporting recovery

Earlier we identified that social inclusion is an essential aspect of recovery.⁵³ People with mental health difficulties want to recover not only their health but their lives. Good quality mental health services support an individual's integration into the community and help them to combat stigma/prejudice and discrimination. The Mental Health Commission's Quality Framework incorporates social inclusion into its standards for mental health services. Standard 2.3 specifies that:

“The mental health service promotes mental health and community integration of mental health service users.”⁵⁴

This standard places a responsibility upon mental health professionals to actively work to facilitate their service users' integration into the local community. However, today the social and economic lives of people with mental health difficulties are at risk in Ireland and people with a mental health condition experience social exclusion:

- People with a long term mental health “disability” participate in the Irish labour force at less than half the rate of the general population⁵⁵
- Adults with a long term mental health “disability” are more likely to have left their job due to their disability than people with other disabilities⁵⁶
- Over half of people whose long term mental health “disability” arose before completing their full time education stopped education due to their disability⁵⁷
- Almost a quarter of those in receipt of illness benefit in 2009 cited ‘stress’ or other mental health issues as the reason for their claim⁵⁸ while more than twenty per cent of people on Disability Allowance had a mental health disability as their primary condition⁵⁹

People identified as having a mental health condition also face stigma, prejudice and discrimination in Ireland:

- In 2006 only 7% of the public thought employers would be willing to hire someone with a mental health problem⁶⁰
- In 2006 people were less comfortable living near a person with a mental

⁵³ See Higgins, A. (2008).

⁵⁴ Mental Health Commission (2007) *Quality Framework: Mental Health Services in Ireland*, Dublin: MHC, p.27.

⁵⁵ Amnesty International Ireland (2010) *The Missing Link: Coordinated Government Action on Mental Health*, Dublin: AI, p.13.

⁵⁶ Central Statistics Office (2009) *National Disability Survey 2006 – Volume 2*. Dublin: CSO, p.85.

⁵⁷ Ibid., p.75.

⁵⁸ The Irish Times ‘25% of sick claims cite mental health’, Wednesday, January 27, 2010 by Mary Minihan.

⁵⁹ Department of Social Protection (2010) *Value for Money Review of the Disability Allowance Scheme*, p.54.

⁶⁰ National Disability Authority (2007) *Public Attitudes to Disability in Ireland*, Dublin: NDA, p.8.

health disability than a person with any other type of disability⁶¹

- In 2010, 47% of the public agreed that a diagnosis of a mental health condition would have a negative effect on their job and career prospects; 37% said it would have a negative effect on their relationships with their work colleagues⁶²
- In 2010, research among more than 300 people with a history of poor mental health found perceptions of having been treated unfairly in every domain of social life including by friends, neighbours, family, health service staff, the police and in housing, education, work, public transport and welfare⁶³

Such social exclusion is compounded for people who live with a mental health condition alongside another diagnosis or disability such as addiction, intellectual disability, physical or sensory disability. Furthermore, the particular challenges of some minority and marginalised groups such as the homeless, travelling community, asylum seekers and the prison population lead to social exclusion and increased mental health difficulties.

Mental health services will be hampered in facilitating recovery if they do not have effective links with local housing, education and employment services. Where such links are currently in place, for example through the job coaching initiative in the DETECT early intervention service, individuals get a better quality service and a better chance of entering and sustaining employment. Similarly, where good links are established with housing services, for example in the Dublin-based homeless outreach mental health services, people at risk of homelessness are more likely to get coordinated housing and mental health support. Such links need to be the norm in mental health services across the country.

Despite the key role that social inclusion plays in recovery there is currently no nationwide measurement of the social inclusion outcomes for mental health service users. The HSE should ensure that indicators for housing, employment, education and income status are collected on a routine basis about people accessing mental health services in order to measure whether service users are achieving improved social and economic outcomes over time.

⁶¹ Ibid., p.36.

⁶² Millward Brown Lansdowne (2010) 'Public attitudes to mental illness: A benchmark study for See Change' available at <http://www.seechange.ie/index.php/stigma-and-discrimination/98-research>

⁶³ MacGabhann, L., Lakeman, R., McGowan, P., Parkins, M., Redmond, M., Sibitz, I., Stevenson, C. and Walsh, J. (2010) *Hear My voice: The Experience of Discrimination by People with Mental Health Problems*, Dublin: Amnesty International Ireland.

6. Challenges and possibilities for stakeholders

The adoption of the recovery principle by the Expert Group that developed *A Vision for Change* poses a major challenge to everyone concerned about mental health in Ireland. The recovery ethos represents a paradigm shift, that is, an over-arching change in the way that we understand poor mental health and corresponding changes in mental health service delivery. The current economic crisis does not negate the need for this paradigm shift, though it may impact on how swiftly the change occurs.

For people experiencing mental distress, the recovery ethos requires a shift from seeking a cure at the hands of professionals to taking responsibility for one's own care and growth. The Wellness Recovery Action Plan is an example of how people who have difficulties with their mental health are taking ownership and responsibility for their own well-being through a process of self-reflection and planning. User expectations of services also can make a difference in shifting the culture. People seeking support need to know what to expect from recovery-orientated services and learn to demand services that offer hope, listening, choice, partnership and social inclusion.

Recovery also poses a challenge to family members and friends of those with a mental health condition. For carers there is a challenge in learning how to support positive risk-taking and autonomy in their relative who lives with a mental health condition, rather than seeking cure and stability at all costs. A willingness to accept repeated failures while maintaining faith and hope in the individual's ability to recover is an important role that carers can play. Carers must also learn to expect services that work in partnership and offer choice for their family member, and they must be ready to work in partnership with their family member and mental health professionals.

For mental health professionals who have invested time and energy in developing their expertise, it can be difficult to let go of a long-held ethos and embrace the recovery paradigm. For them, the challenge is to soften their expert role, to recognise that there are many types of expertise, including the expertise that comes from lived experience with a mental health condition. Then, mental health professionals can continue to value their own clinical knowledge and experience while re-imagining their role to be as facilitators of recovery. While clinical knowledge and skills offer a valuable resource for decision-making about an individual's recovery plan, Mental Health Reform believes that a modern mental health service requires a new role for all staff working in mental health services as facilitators, 'coaches' or 'guides' working in partnership with the person with mental health difficulties to support their recovery. Such an approach does not negate the value of clinical expertise, but views such expertise as one of many valued resources. According to Mike Slade such a facilitator, or 'coach' role involves:

1. Assuming that the person is or will be competent to manage their life.
2. Ensuring that the focus is on facilitating the process of recovery to happen rather than on the person. Coaching is about how the person can live with mental illness [*sic*] and differs from a clinical focus on treating the mental illness [*sic*].
3. Enabling this self-righting capacity to become active, rather than to fix the problem. This leads to amplification of strengths and natural supports, rather than of deficits.
4. Effort in the coaching relationship being directed towards the goals of the coachee, not the coach. The skills of the coach are a resource to be offered. Using these skills is not an end in itself.
5. Both participants making an active contribution for the relationship to work.⁶⁴

The recovery paradigm also poses a challenge to local communities and to Irish society as a whole. Local communities must be willing to accept risk, to allow individuals with mental health difficulties to try and fail and try again in their personal journey towards recovery. Local communities can have a profoundly positive influence on an individual's recovery by treating people with a mental health condition with respect, empathy and concern in their daily social interactions. Work colleagues and employers have a similar opportunity to support recovery within workplaces, by responding to colleagues who develop mental health difficulties with empathy, acceptance and support.

On a national basis, public leaders must be willing to accept and support positive risk-taking by people with a mental health condition. This will require widespread public education about mental health and well-being, going beyond the current anti-suicide and anti-stigma campaigns to developing widespread public mental health promotion. Government must also prioritise implementation of the recovery principle in *A Vision for Change*.

Conclusion

In this paper, we have described the concept of recovery and identified the five core components that make up a recovery approach to mental health service delivery. We have also offered constructive suggestions for how to implement the recovery ethos within the mental health services. Mental Health Reform seeks to be a positive resource for all stakeholders working towards embedding the recovery ethos in mental health services. We aim to facilitate dialogue between mental health professionals, to inform people with a mental health condition and family members and to promote the empowerment of users of services. We believe that only by working together can the principle of recovery set out in *A Vision for Change* become realised in the day-to-day response to mental health in Ireland.

⁶⁴ Quoted from Slade, M. (2009), Op. Cit., p.123.

About Mental Health Reform

Mental Health Reform is the national coalition of organisations working to promote improved mental health services and social inclusion of people with mental health conditions in Ireland. We work with our members to help bring about structural and cultural changes in mental health services.



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