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PERSPECTIVE

The recovery ethos: towards a shared understanding

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This article presents Mental Health Reform's perspective on the recovery ethos for mental health service delivery derived from Irish stakeholders' perspectives. It arose out of a project to develop Mental Health Reform's agenda for advocacy to implement *A Vision for Change.* The article describes five core components of a recovery-orientated service: hope, listening, choice, partnership and social inclusion. The article also describes briefly how each component can be reflected in mental health service delivery. The recovery ethos can provide a way forward for service delivery within the current economic crisis and may be viewed as a tool for responding positively to the crisis rather than an additional burden.

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Introduction

The recovery principle set out in the Government's mental health policy *A Vision for Change* represents a conceptual challenge to reform of the mental health services. Pointing beyond issues of quality, scope and structure, the recovery principle evokes a new ethos to underpin service delivery. While the Mental Health Commission has provided guidance on the recovery ethos (Higgins, 2008) and both the HSE and the College of Psychiatry are preparing guidance papers on the issue, there has yet to be developed a broad-based view generated from the voluntary mental health sector.

This article describes Mental Health Reform's perspective on the recovery ethos and its implications for mental health service delivery. Mental Health Reform's perspective is rooted in the views of people who have received mental health treatment and their family members, and arose out of a project to develop Mental Health Reform's agenda for advocacy to implement *A Vision for Change.*

Mental Health Reform's *Manifesto – Guiding A Vision for Change* was developed through a national consultation process. This involved eight public meetings in locations that spanned the four health service regions. Attendees were predominantly users of services and family members but included staff of local mental health services and staff from local voluntary sector services.[1] Approximately 350 individuals participated in the consultation meetings that were held from September to December 2011. At each meeting, roundtable discussion took place where attendees were asked what they found positive and what they found unhelpful or missing from mental health services. Notes were taken at each roundtable and once transcribed these were reviewed for themes related to the literature on the recovery ethos. The resulting categories were verified in a meeting with Amnesty International Ireland's advisory group of individuals with personal experience of a mental health condition. The draft report was considered by Mental Health Reform's multi-disciplinary advisory group consisting of representatives from each of the professional associations involved in delivering mental health services. The draft report was also peer reviewed by a panel of international and national experts including William Anthony, Mike Slade, Michaela Amering and Agnes Higgins.

Mental Health Reform's articulation of the recovery ethos also reflects input from our member organisations, who include a broad base of mental health interest groups. Voluntary organisations that provide mental health support and information are members, as well as organisations who work in other areas including homelessness and housing, disability, human rights, community development, prison reform and refugees and who consider mental health an important aspect of their work. Our membership also includes professional associations such as the Irish Association for Counselling and Psychotherapy, the Irish Council for Psychotherapy and the College of Psychiatry of Ireland. This broad base of membership provides a well-grounded basis for our perspective on recovery (Fig. 1).

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[1] Six public consultation meetings were organised in partnership with People with Disabilities Ireland and two were hosted solely by Mental Health Reform. Meetings were organised with the assistance of the National Service User Executive.

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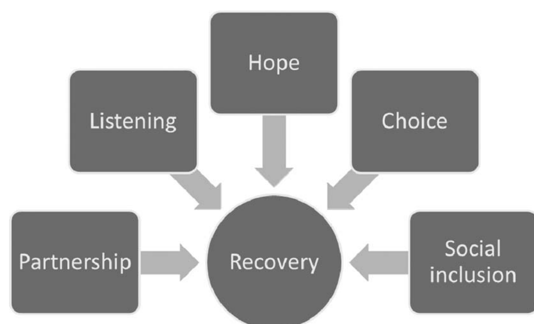

Figure 1. Five key building blocks of a recovery-orientated approach.

Mental Health Reform has identified five core components of a recovery-orientated service: hope, listening, choice, partnership and social inclusion. In the remainder of this article, I will explain the meaning of each component and how they might be recognised within mental health services.

Hope

One hallmark of a recovery-orientated mental health service is a hopeful attitude conveyed by staff. People 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 a key factor in their beginning to act to help themselves. Patricia Deegan has also described the importance of the hope expressed by those around her as a factor in her recovery (Deegan, 1988). In Ireland, Kartalova-Doherty and Tedstone Doherty reported that service users identified hope as a facilitator of recovery (Kartalova-O'Doherty & Tedstone Doherty, 2010), while in Watts' study of recovery within GROW services he found that 'many participants suggested that it was the awakening of hope that became the primary catalyst of recovery' (Watts, 2012).

Mental health professionals who work within a recovery ethos convey an expectation of recovery and ensure that their behaviour demonstrates belief in the individual's strengths and capacities. Conveying hope means having a positive expectation about the person's future and expressing belief in that person's capacity to lead a fulfilling life. Hope also includes focussing on the person's strengths rather than their deficits and building on their capacities rather than only seeking to eliminate or cover over their incapacity. In practical terms, implementing a hopeful attitude entails using strengths-based assessments as part of recovery planning.

Another practical means of engendering hope is to incorporate positive role models as part of service delivery. Bringing people with poor mental health into contact with those who are in recovery is an effective way of fostering hope. 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 (Deegan, 1988).

Listening

A consistent feature of individuals' descriptions of negative experiences within mental health services, both those receiving treatment and family members, is the feeling of not being heard. Sometimes people experience a lack of listening when they or their family member are in a crisis or trying to get help at a point when the individual's mental health is deteriorating. One individual described how he had tried to get help when he was starting to 'feel ill' and was told that he could not see the doctor that day because he did not have an appointment. The same person described not being listened to about his suggestions for his treatment:

> I'm not being heard or I'm not being listened to… At the moment I'm on 100 mgs of sodium but I feel like if I go in and tell him this, he'd be trying to bully me into taking what he thinks is a suitable dose.

Mental health professionals who work within a recovery ethos listen to the individual who is seeking help with attentiveness. This listening involves three aspects:

1. Listening to the individual's personal understandings of their condition. Individual service users may have different values to those of their treating clinician, values which need to be respected. The individual's interpretation of their experience may differ from the clinician's and though it may not appear to be clinically significant, the individual's interpretation may be equally important for determining appropriate support. It is important to acknowledge and respect the individual's own understanding of his/her experiences as part of respect for his/her culture and values.
2. Listening to the individual's aspirations and goals for his/her life. Only by understanding what the individual wants to get out of life can the mental health professional ensure that support is organised

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in a way that supports the person's life goals, rather than hinders them.

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 recovery planning.

Family members and friends also need to be heard. Mental Health Reform has heard both positive and negative feedback from family members. For example, one family member had noticed improvement in his access to the mental health professional team as compared with the past. Many family members wanted to be contacted as a resource to support their loved one's recovery, but many also described a lack of inclusion in care planning and a lack of support for their own needs. One family member resorted to calling the Samaritans for support when his/her needs were not met by the mental health team.

Where permission has been given by the individual concerned, family members can provide useful information to mental health workers about what triggers the individual's mental distress, the usual signs when the individual is starting to deteriorate and what has helped their loved one to recover in the past. Sometimes they can identify when their loved one needs crisis support at times when the individual concerned is not able to ask for help. Family members may have their own needs for mental health support as well; listening to family members' concerns may help to alert mental health staff to family members' own mental health needs. The Mental Health Commission (Byrne & Onyett, 2010) has stated that community mental health teams should provide support to family members, including ongoing emotional support, respite care, assistance with accessing other types of services and education about mental health.

Partnership

At a one-to-one level, working with service users as equal partners in their own care is essential to re-balancing 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.

Participation is also a core component of an approach based on human rights. The preamble of the Convention on the Rights of Persons with Disabilities recognises that people with disabilities 'should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them'. Participation by individuals in decisions affecting them is a crucial element of the right to health as set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights.

Recovery planning involves a dialogue between the individual concerned, professional and carer (where relevant) in which meaningful communication about both the understanding of the 'problem' and the steps towards recovery takes place. Each participant has a valued role to play in this dialogue so that the combined expertise of clinician, person with poor mental health and relative can be brought to bear on the perceived difficulty. And even though the ultimate decision must rest with the individual about his/her mental health treatment, the best outcomes are likely to come through shared learning between all parties.

Family members and close friends can 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 and close friends have a good understanding of mental health conditions and ways of coping, they can play a positive role in supporting recovery. Participants in Mental Health Reform's consultative meetings commented on the important role that family members play in recovery, their need for education about mental health and their need for support. In Mental Health Reform's view, wherever appropriate, services should reach out to family members/significant others as partners in providing support.

Choice

People in Ireland have been calling for greater choice in mental health treatments for many years and this issue was again raised in Mental Health Reform's consultation meetings. Participants identified the over-reliance on medication and the lack of talking therapies as gaps in services in some areas. *A Vision for Change* affirms that service users want alternatives to medication and wider availability of psychological therapies. People must be offered choices – of treatments and therapies, of who provides their care, of when and where supports are provided.

Choice is an essential component of a recovery-oriented service because only where the service user has real choices can he/she achieve autonomy and

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self-determination. 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, in Mental Health Reform's view 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.

To be able to make well-informed choices, individuals need good quality, comprehensive and balanced information, including information about the risks and benefits of treatments. Thus, another hallmark of a recovery-orientated service is the provision of transparent, accessible information about treatments.

Social inclusion

A key aspect of the recovery ethos is the recognition that recovery is about more than reducing mental health symptoms – it concerns developing a meaningful life. People spoke to us about how employment can give a person a reason to get up in the morning, and how they need opportunities to get involved in their local community.

Recovery-orientated mental health services have an important role to play in supporting people with a mental health condition to participate in their local community, have social relationships and engage in meaningful activities including education and employment (Repper & Perkins, 2003). This includes helping those at risk of homelessness to secure housing and developing relationships with local mainstream services such as training and education, employment support and housing providers. In this way, community mental health staff become a bridge between the mental health services and other community supports, services and activities. Mental health staff have a role to play in supporting people to claim their rights and entitlements by raising awareness of social welfare and housing entitlements and providing information about advocacy services. Equally, local staff of public and community services must play their part in supporting individuals with a mental health condition.

Conclusion: implementing recovery in a time of economic crisis

It would be tempting to consider this vision of a recovery-orientated service as ambitious. One could argue that current resource constraints imposed on the public mental health services make such a reform unrealistic. Certainly, taking the time to listen to service users' interpretations of their condition, life goals and self-management techniques requires resources. So too, engaging in dialogue rather than unilateral decision-making takes time. But one might well ask how efficient a service is that does not listen to its customers? When people receiving treatment are not listened to, they may ignore professional advice, or stop treatment. Just as bad, they may continue to endure unhelpful treatment for many years without recovering the quality of life and full citizenship that they could. Services that listen to their 'customers' are likely to produce better outcomes based on support that reflects the individual's needs and life goals.

The recovery ethos also implies greater responsibility on the part of those in recovery and this points to a way forward within the current economic crisis. If partnership is about the involvement of at least two parties, then people who use mental health services must also be more active participants in their own mental health care. Greater personal responsibility for recovery through self-management offers a way forward for services that cannot meet the demand with a traditional approach. From this perspective, the recovery ethos provides a new role for mental health professionals as facilitators of a process for the individual to develop self-care, rather than sole providers of care. This may be the only way forward – to adopt a mode of service delivery that strengthens the individual's capacity to manage and sustain their own mental health, drawing upon the support of family and friends and wider resources in the community. Viewed in this way, the recovery ethos becomes a tool for responding to the economic crisis rather than an additional burden. Those services that are ready to take on the challenge of the recovery ethos may well be best placed to survive and thrive in the future.

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