Chapter 1

Introduction: The Emergence of Recovery as a Key Concept

Stephan D. Kirby, Angela Hall and Mike Wren

Teeside University, UK

> *We shall never cease from exploration. And the end of all our exploring*
> *Will be to arrive where we started. And know the place for the first time*
>
> T.S. Eliot (*Little Gidding*)

At the end of the first edition, we left you with two rhetorical questions that arose as a consequence of producing that text:

> *How different would services look if their primary focus was to enable people to use and develop their skills, make the most of their assets and pursue their aspirations?*,

and

> *Would this not change, for the better, the experience of using services, and the relationship between workers, and those whom we serve?* (Repper & Perkins, 2003:11)

In this second edition, we hope to address these questions and in doing so raise your awareness of wider issues and concepts so that you are better informed to decide if you want to be agents of and for the organisation or champions of future change.

Building upon the strengths of our previous book (still available at all good book sellers, Blackwell Publishing website and Amazon), this current text utilises a more conceptual and person-focused approach that will enable the reader to plan for the future, and to challenge political, medical, social and professional identity issues. It is worth pointing out that even though this is a second edition, we have not simply, as is traditional, taken

the original chapters and updated them; rather, we have preferred to reflect the developments and advances in mental health care and recovery. We felt it was important that the book reflected the notion that care planning is not simply APIE; rather, it is a move from a professional model focus to the active promotion of the person and their individually constructed narrative. So by engaging with the person's resilience, reserves and inner resources, we are able to focus recovery work around the individual, their story, hopes, dreams, skills and strengths rather than the symptoms of their mental distress (Saleebey, 2009). To address this paradigm shift, our stance within this text openly acknowledges, introduces and applies a variety of differing concepts and ideas underpinning the fact that we best serve people on their journey to recovery by collaborating with them (White & Epstein, 1990).

The reader will find (and we make no apologies for this) that there is no – or very little – explicit mention of APIE as a care-planning process. Whilst this is inherent within the text, it is not the primary focus of this work; rather, we are offering the reader insights into ways of approaching and understanding an alternative underpinning philosophy when implementing care planning in mental health. The structures of Care Planning are well documented and established within the delivery of mental health care; what we hope the reader will gain from this text is a more enlightened and person-focused way of approaching the activities involved in planning collaborative, interprofessional and person-centred care that gives the person with the mental health problem the hope, optimism and opportunity to express their own desires, aspirations and potential that will enhance their journey on the road to recovery.

In the first edition, we attempted to address the issues around recovery as a concept and its application within the care-planning process. However, we were directed by the traditional and dominant frameworks that pervade mental health: such as Care Programme Approach (CPA), a range of 'new' legislations (e.g., the then proposed amendment of the Mental Health Act 1983 (DoH, 1983), the influences of numerous medical model-focused clinical practice guidelines and not forgetting the APIE of the prescriptive Nursing Process. The dominant culture within mental health has prevented professionals from challenging and progressing recovery-focused practice and has made them into (despite their good intentions and desires) passive recipients of the status quo which is shrouded in new terminology and contemporary rhetoric. They become afraid to deviate from this to embrace the recovery concepts as these are often questioned by the organisation as they are not seen to be part of the corporate vision and identity, which is invariably based upon financial requirements and popular trends with no thought for the people receiving and centrally involved in the care. In policy terms, mental health needs to be more concerned with health and wellbeing as well as providing direct support to people to enable them to function as full citizens in their communities (DoH, 2007). 'Increasingly services aim to go beyond

traditional clinical care and help patients back into mainstream society, redefining recovery to incorporate quality of life – a job – a decent place to live – friends and a social life' (Appleby, 2007).

We are conscious that there have been major changes in mental health in the years between these two editions. These encompass a refocusing of organisational structure, culture and delivery models. We have continued to see legislative documents and dictates published as well as the further move into community care and, in some cases, even the rebirth and refocus of inpatient provision. Most importantly is the drive, through education and into services, towards the further promotion of the recipient of mental health services being accepted as human beings and equal partners.

This has reawakened the emphasis on 'The Person' (their essence, attributes, uniqueness and individuality and all the factors that exert an influence on personhood) and the hopeful demise of interchangeable labels of stigma, discrimination and depersonalisation. It is obvious that there are, and will be, difficulties and resistances to the professional's acceptance and adoption of these 'new' (though not really new, just old ideas rebranded and repackaged) ways of perceiving the new mental health landscape. There are resistors from all sides, the need to meet organisational targets (the ubiquitous audits and quotas which appear to (and indeed *do*) drive and underpin service provision), both the personal and organisational paranoia of litigation that appears to underpin service delivery today; and the need to have every meeting with the person with the mental health problem; every action; assessment; intervention and interaction recorded and rated on a sliding scale of risk and the appropriate risk management strategies created accordingly. There are ever-decreasing timescales and ever-increasing caseloads that services have to contend with, as well as the change in funding and the move towards a market-led provision with GP fund holding imminent; resistance from individuals and organisations abound. Organisations are being driven by 'New Managerialism' (Hafford-Letchfield, 2009) which relies on targets and outcome-driven agendas and where the illusion of being an involved customer is created and maintained, but in reality, people are merely a commodity of the market place. Recovery provides a new rationale for mental health services and has implications for the design and operation of mental health services and partnerships between health, social services and third-sector organisations (Shepherd *et al.*, 2008).

Whilst in the latter half of the last century, recovery was thought to be an alien concept (Coleman, 1999), it is now firmly on agendas; indeed, it *is* the agenda. Work started by Romme and Escher in their seminal work with voice hearers started a paradigm shift (Romme & Escher, 1993) and it is up to everybody to continue that work until the shift is complete. The Hearing Voices Network, informed by this work of Romme and Escher, works positively with people's experiences of hearing voices (Rogers & Pilgrim, 2010). Rather than trying to obliterate the voices, as a traditional symptom-based

approach might do, this user-led initiative attributes meaning to voice hearing. This offers alternative means of coping with voices that may at times cause their recipients distress. Recovery as an idea, a concept and a care focus has now come of age and its importance has been recognised and acknowledged and it provides a new rationale for mental health services (Shepherd *et al.*, 2008). It is based on the notions of self-determination and self-management and emphasises the importance of 'hope' in sustaining motivation (Shepherd *et al.*, 2008). It has become the key principle underlying mental health services across the world, for example, New Zealand (Mental Health Commission, 1998), the United States (Department of Health and Human Services, 2003), Australia (Australian Government, 2003), Ireland (Mental Health Commission, 2005), Scotland (Scotland Government, 2006) and in England (DoH, 2001, 2006, 2007).

Ron Coleman (Coleman, 1999) tells us that there is a common joke amongst people with mental health problems that they all understand, 'What is the difference between God and a Psychiatrist? Answer: God does not think he is a Psychiatrist'. He continues that there is another major difference between God and Psychiatrists: while 'God created the world in 7 days, a Psychiatrist can change a person's in little under an hour' (Coleman, 1999:7). It is no surprise therefore that the road to recovery is difficult and fraught with dangers and traumas, but the road to illness is surprisingly easy – far too easy (Coleman, 1999:7).

It must be pointed out though that this somewhat scathing attitude towards psychiatry and psychiatrists was taken from a number of years earlier in Ron's career towards 'product champion and leader' for voice hearing and trainer for voice hearers. This was a period when clear, distinct lines of battle were drawn between professionals and purveyors of psychiatry and the population that were deemed to be in need, usually against their free will and without consultation, of such disempowering actions. However, as years have passed and with the advent of mental health, so has the culture and climate of recovery. The culture and infantilising nature of psychiatry is diminishing, and partnership working and engagement and empowerment from a recovery framework is growing. Ron and many of his contemporaries now collaborate closely with psychiatrists; indeed, some of his working partners and trainees are psychiatrists. Traditionally, the medical model has served as a means of deflecting attention away from the person and their lived experience(s). None of this is a condemnation of the medical model and psychiatry (as opposed to mental health) per se, but acknowledges the fact that there are limitations to this particular way of representing the experience(s) and problems of living for the person with mental health problems (Barker, 2001). Nor does it, or should it, promote the exclusion of the medical model from the mental health care arena or from the delivery of a person-focused approach to mental health care recovery. Rather, it has its place as does every other approach and discourse; there are times when paternalistic decision making has to occur without the person's involvement and for their best interest. Similarly, there are times, as

the person progresses through the phases of recovery, where this approach has to take a back seat and allow the more person-centred, empowering and self-management approach to occur. One that affords the person more growth opportunities towards, and along, an empowering, person-centred approach to recovery within mental health recovery.

But what is recovery? It has been said (Coleman, 1999) that professionals define recovery as maintaining a person in a stable condition, regardless of issues such as adverse effects of medication or even the expressed wish of the person. However, from the person experiencing the mental health problems, recovery is a personal construct, one that is defined by the person themselves, based upon their own experiences and resources. Importantly, the essence of clinical recovery is based upon the premise that clinical recovery occurs because of the effectiveness of the clinical treatment. It is this aspect of recovery, effective (person-centred) treatment that this book is hoping to capture and promote. Recovery is also seen (Anthony, 1993) to be '…a deeply personal, unique process of changing one's attitudes, values, feelings, goals and/or roles…a way of living a satisfying, hopeful and contributing life even with the limitations caused by the illness…the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness' (p. 17).

Shepherd *et al.* (2008) offer what they propose to be the key themes of recovery, these being:

1) **Agency** – gaining a sense of control over one's life and one's illness. Finding personal meaning – an identity which incorporates illness, but retains a positive sense of self;
2) **Opportunity** – building a life beyond illness. Using nonmental health agencies, informal supports and natural social networks to achieve integration and social inclusion;
3) **Hope** – believing that one can still pursue one's own hopes and dreams, even with the continuing presence of illness. Not settling for less, that is, the reduced expectations of others.

<div align="right">(Shepherd <i>et al.</i>, 2008)</div>

These three overarching themes of recovery were taken on board by the Devon Recovery Group and resulted in the following Principles of Recovery (see Box 1.1). This resulting set of principles (Davidson, 2008) clearly demonstrates an active collaboration of the mutual roles, responsibilities and resources which aim to promote the person, their experience(s) of mental health problems and also reflect a desire and drive to capture the essence of their recovery. These are seen, by the editors, as being key concepts of 'making recovery a reality' (to borrow a phrase from the Sainsbury Centre) and through which we discover the person, their life and celebrate their diversity for, and opportunities to, change. These principles were the inspiration behind, and also formed the underlying belief system for, the development of this text.

Box 1.1   The principles of recovery.

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems;
- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness;
- Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward;
- Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No 'one size fits all';
- The helping relationship between clinicians and patients moves away from being expert/patient to being 'coaches' or 'partners' on a journey of discovery. Clinicians are there to be 'on tap, not on top';
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services;
- Recovery is about discovering – or rediscovering – a sense of personal identity, separate from illness or disability;
- The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity;
- The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience;
- Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.

(Davidson, 2008; Shepherd *et al*., 2008)

One of the central and primary principles of recovery is the notion that it does not necessarily mean cure (clinical recovery); rather, it acknowledges the unique journey a person goes through when building a life beyond mental illness (social recovery) (Shepherd *et al*., 2008). People have to come to terms with the trauma that the occurrence of mental health symptoms can have on their lives and incorporate these experiences into a new sense of personal identity (Larsen, 2004).

Such traumas can only be resolved if the person can discover – or rediscover – their sense of, and ability to action, personal control (agency) and thus gain a belief in the future (hope); and without hope, (re)building lives cannot begin. Recovery is about this process and the *quality* of this experience is central (Shepherd *et al*., 2008). The power of, and responsibility for, recovery lies within us – all *users*, professionals and carers – and this can only be achieved by working together, by talking and listening to each other. This can only be done by a paradigm shift from the dominant biological reductionism to one of personal and societal development (Coleman, 1999). This road to self-discovery starts when you look at your own life and how events outside have affected you this includes family, friends, traumatic experiences and life

events and how you feel about the things that have happened. A turning point for many people in recovery can be taking the first steps to dealing with feelings of guilt and inadequacy for something you probably have little or no control over. Recovery should follow the premise that professionals should be on tap; not on top (Repper & Perkins, 2003).

Recovery is applicable and appropriate to anyone who experiences a significant mental health problem at any age as well as applied in specialist areas such as forensic mental health services, CAMH Services and Drug and Alcohol Services, and management relies heavily on the provision of information and self-management in addition to treatment and symptom control (Shepherd *et al.*, 2008). Recovery is our common goal, and it is now achievable, so we should not lose the moment for we need to work together to make it happen, and we need to put our past (professional) differences behind us to let us go forward towards recovery (Coleman, 1999).

Many of the ideas underpinning the recovery philosophy are not new (Shepherd *et al.*, 2008). They come from the consumer/survivor movement of the 1980s and 1990s which ran along the lines of self-help, empowerment and advocacy. This was the basis of challenging traditional notions of professional power and expertise which pervaded mental health services (and arguably still do) (Shepherd *et al.*, 2008). These ideas themselves have their roots in the Civil Rights movements of the 1960s and 1970s in the US and in self-help and politically motivated groups such as Mad Pride, Survivor's Speak Out and The Lunatic Liberation Front. From this patients were beginning to be seen, and see themselves, as victims and then survivors of mental health – a notion equitable to those people who survived the concentration camps. Between 1970 and 1990, mental health survivor activity in the UK saw a range of user-led organisations arguing either for the abolition of psychiatry or for its radical reform. These included the 'BNAP' (British Network of Alternatives to Psychiatry), 'PROMPT' (Protection of the Rights of Mental Patients in Therapy) and 'CAPO' (Campaign Against Psychiatric Oppression) (Rogers & Pilgrim, 2010). However, the current recovery movement and frameworks, supported and adopted as they are by a wider range of participants (professionals and users, groups and official bodies), no longer have the political undercurrents of the earlier movements (Shepherd *et al.*, 2008).

There are continuous and consistent concerns that recovery in mental health is being, indeed already has been, hijacked by professionals and that they are rebranding it into a technology, a science, absorbing it into the academic domain and in doing so making it their own. Recovery is now perceived to be a term that is used, possibly indiscriminately, by professionals to represent a panacea of all mental woes; the new 'holism'. The term recovery is used in different contexts by both people with mental health problems and mental health professionals. As recovery ideas have been devised by, and for, patients to describe their individual experiences of their mental health, professionals need to be aware that accusations may be levelled at them for

taking over the concept of recovery. There are product champions from both sides who continue to publish around and promote recovery. Despite national policies and frameworks (Shepherd *et al.*, 2008) from a number of diverse organisations, the mental health system continues to be patriarchal and bureaucratic, and ever increasingly so as the years progress and with each subsequent 'development and improvement'.

For recovery to become a reality, professionals need to fully understand the concept of recovery and what it means from a patient perspective so that they can work with the person in the recovery process (Shepherd *et al.*, 2008). Mental health professionals should challenge their own, as well as each other's, negative assumptions and detrimental communications and interactions and strive towards positive attitudes and attributes, because until a sound, collaborative rapport is formed, it is not possible to facilitate a psychoeducational approach. Through the continued usage and promotion of this conceptual shift, one that is mutually beneficial and dynamic and within the framework of interprofessional (partnership) working, the realities of emancipation and empowerment will continue to enable people to no longer 'just exist' but to now 'thrive' in contemporary mental health.

Before we introduce the individual chapters, we would like to offer a quick word on terminology. Language in mental health is a constant site of debate and struggle (Barnes & Bowl, 2001). Not all people with mental health problems reject the notion of 'mental illness', although some do consider the notion of 'illness' an inappropriate and outdated manner of understanding and describing their distress. Similarly, others reject the label 'service user', because of an implication of active engagement with services which does not match their experiences of mental health. 'Consumer' is a term associated with the market and business domains. Others have adopted the terms 'victims' or 'survivor' to portray either a negative or positive image of people in distress and people whose experiences differ from, or who dissent from, society's norms (Barnes & Bowl, 2001). To this end in this text, the reader will find a number of differing terms used throughout the chapters by the differing authors. These are not necessarily those that would have been chosen by the editors, nor by the individual authors themselves; rather, they are used to describe, in a generic, easily conceptualised, widely used and conventional manner, the person who has mental health problems and who engages (or comes into contact) with mental health services. Throughout the editors' individual and combined chapters, they have chosen the term 'person with the mental health problem' – or some derivative – while other authors have gone for the easily understood and conceptualised term of 'patient'; neither – or all – is necessarily always correct or appropriate. The debate regarding a correct term that appropriately describes a person with mental health problems continues, which is why we have chosen to use this term as it is the nearest we can find to a term; a 'label' that does not (hopefully) become a source of

discrimination or negativity thus social control and stigma. Even by using a 'soft' term like 'person with mental health problems/person with experiences' is, in itself, a form of labelling; so we are as guilty as anybody of forcing people into categories. Indeed, why do we have to have a nomenclature, a label or some different way of talking about people; surely, they are just 'people' like you and I.

The individual chapters (as summarised in the following text) are grouped into three sections which we believe capture the essence of recovery: 'Survive', 'Manage' and 'Thrive'.

According to Kaplan (1964), when people experience and respond to distress they start to make sense of this; to explain it and to understand it, in essence to survive – despite the difficulties that are happening to them. This starts by people acknowledging they have a problem and seeking assistance wherever they can (or, in some cases, have assistance thrust upon them). Kaplan devised a framework of preventative psychiatry where the person passes through three distinct phases: primary, secondary and tertiary. This moved the person from a point of psychological distress, through diagnosis and treatment to long-term disability. Devised as this was in the 1960s, the recovery model or focus did not exist; indeed, mental health services were exclusively institutional. Hence, Kaplan's model was a reflection of its times. As we moved away from the Institutional Model of mental health, community care has allowed us to see and utilise a more recovery focus to care delivery and services.

Our framework and understanding of the domains of 'Survive', 'Manage' and 'Thrive' reflects, somewhat, Kaplan's (1964) 'Primary', 'Secondary' and 'Tertiary' approach to preventative psychiatry. However, he defined tertiary as a long-term (institutional) care approach for people who had acquired chronicity and were thus engaging on a long-term basis with (institutional) mental health services. We have brought this up to date, and use the domain of 'Thrive' to explain a situation where the person does not seek nor accept chronicity and long-term institutional care. Rather, they seek ongoing recovery and ownership of their illness to a point where they are functioning within a social world to the best of their abilities and skills and continue to learn more about, and engage with, their symptomologies and pathologies, that is, recovery. To enable this to happen, we need, in practical and dynamic ways, to change the 'Manage' aspect of this, that is, the culture and the mindset and practices of people within the organisations, services and cultures. We need to continue to encourage and adopt more interprofessional working activities that include as an equal partner the person with the mental illness.

Our model (and further explanation of the domains of 'Strive', 'Manage' and 'Thrive' and how they interconnect and influence each other) can be found in Chapter 14 and is a visual representation of the amalgamation of all our thoughts and ideas that have driven the development of this text as well

as the learning and awareness raising we wished the reader to engage with. It is an amalgamation of Watkins (2001), Kirby (2001) and Kirby & Cross (2002), and we feel this captures the essence of recovery within contemporary, interprofessional, person-centred mental health care.

The chapters

Chapter 2: Experiencing recovery
(Aidan Moesby and Sandra Cleminson)

Through sharing his experiences as a recipient of mental health services, Aidan shares with us the ups and downs, his good and the bad experiences on the road to recovery from a major mental health issue. Through this autobiographical exploration, he offers some clear messages regarding service provision by identifying what made a good, proactive, recovery-focused service and what did not. He clearly shows that effective and wide-ranging support throughout the recovery journey is essential to successful outcomes. This narrative highlights how services can and should meet the needs of the people that need them. It clearly shows that for mental health services to support recovery, they should be tailor-made to the individual and be in the form of what is required on a spectrum of support which is accessible, prevents relapse, empowers and is flexible to need, whilst fostering independence and self-reliance through the use of a model of interprofessional working and recovery.

Chapter 3: Recovery as a framework for care planning
(Jim Campbell, Theo Stickley, Sarah Bonney and Nicola Wright)

In this chapter, Jim and colleagues show how the environment of care that is provided by the mental health professional needs to be supportive and facilitative so that life has meaning for the person with mental health problems. This chapter offers guidance for mental health practitioners to enable them to provide successful recovery-focused mental health care through frameworks for planning care. By drawing on the Sainsbury Centre for Mental Health's Framework for Organisational Change, they show how mental health services need to, and could, change to encompass the concept of recovery. They discuss its values and principles which provide a foundation for more meaningful mental health care, drawing on practical applications and examples from around the world. This chapter then, drawing on literature reviews, offers a number of themes that constitute effective individual recovery and shows how recovery should and could be the norm and how it is a move away from the medical definitions of mental illness to the social construction of recovery; it *can* be normal to be different.

Chapter 4: Discovering the person
(Angela Hall and Donna Piper)

Angela and Donna are asking the salient question of 'do we ever really know anybody' as we only let people see certain aspects of ourselves and our worlds. This is particularly true when a person is going through the turmoil of a crisis in their mental health problems. They propose that effective, recovery-focused assessment can allow professionals come to know people in a more meaningful, less medicalised way. They demonstrate that the use of the term 'assessment' has implications of medicalisation, categorisation and making judgements through the use of structured or outcome-focused tools, which compartmentalise the individual, and how we need to focus this process more on learning about the person with the mental health problems, about their lives, their experiences, their abilities and limitations – the need to capture the richer narratives and discourses. They leave the reader with a very powerful message that we need to really look, not just see, and that we need to listen, and not just hear.

Chapter 5: Parity of esteem
(Mike Wren and Natalie Iley)

Mike and Natalie discuss essential lifestyle planning, which is based on the experiences derived from the person experiencing mental health problems, and go on to discuss the concept of parity of esteem, and how this can reclaim a person's sense of recovery. They introduce the concept, and usage, of 'recovery brokers' who would promote independent functioning with greater credence being given to the personal narrative of the person with mental health problems. They show how this would be underpinned and guided by effective communication, collaboration and coordination. If the development of personal parity of esteem is successful, then the person with the mental health problems would experience 'survivors pride' and have more beneficial experiences and outcomes on their road to recovery.

Chapter 6: Holistic care: physical health, mental health and social factors
(Teresa Moore and Scott Godfrey)

The term 'wellbeing' refers to the achievement of a positive physical, social and mental state as opposed to the absence of mental illness or disease. It is with this premise that Teresa and Scott demonstrate the complex

interface of holistic (mental and physical) health care. They clearly show that all forms of mental illness are at increased risk of physical illness and as a consequence can expect a considerably shortened life span as a direct result of mental illness. They also state that as a result of their mental health problems, people are also less likely to access public health initiatives including health screening making early disease detection or intervention less likely. By improving physical health and life expectancy, better educational achievement and employment rates and productivity, reduced antisocial behaviour and criminality and reduced levels of risky behaviours including smoking and alcohol and substance misuse, we can achieve this status of wellbeing for people with mental health problems. It is obvious that any mental health recovery without the inclusion of this holistic dynamism is not complete nor is true to our collaborative partners in care.

Chapter 7: Strengths and diversities: a substance misuse perspective
(Julie Wardell)

By opening her chapter with a very pertinent question, Julie tells us that this is the question asked by anyone interested in the effective promotion of recovery for people who misuse substances (but equally applicable to people with mental health problems). She goes on (while focusing on the Substance Misusing population) to untangle the complex debates regarding the safest and most successful routes to improving an individual's life chances and realising their potential. This chapter then explores ways of working with individuals to promote recovery, such as strengths-based and motivational change practice as well as further identifying and exploring the importance of working with individuals in a person-focused way, to elicit hope, aspirations, strengths and goals.

Chapter 8: The legal and ethical landscape
(Charlotte Chisnell and Gordon Mitchell)

By discussing the recent changes that have been made in relation to mental health legislation, Charlotte and Gordon demonstrate how these changes are compatible with recent Government policy drivers that endorse a recovery model of service provision and enablement. This shows that the recent legislative changes set out to improve outcomes for people with mental health issues. However, they remind us that despite current policy promoting recovery and the involvement of the person with the mental health problem,

ultimately the purpose of the majority of mental health legislations continues to focus on risk and protection.

Chapter 9: Enabling risk to aid recovery
(Angela Hall)

This chapter focuses not so much on Risk *within* recovery or the risks inherent in engaging in the Recovery Process, rather it explores the importance of risk and assessing and managing this to enable effective and safe recovery to take place. Angela explores the concept of risk and positive risk management in the context of contemporary mental health care planning. A recovery approach will be described when trying to measure and predict risk, and the need for a collaborative process in order to enable risks to be taken with the aim of promoting the person's journey of recovery. The chapter concludes with a case scenario that requires readers to consider decision making and risk taking in relation to promoting recovery as part of the care planning/ planning care process.

Chapter 10: Collaborating across the boundaries
(Mike Wren, Stephan D. Kirby and Angela Hall)

By exploring the core features which are vital to any professional involved in the life of a person with mental health problems, the editors of this book demonstrate the necessity for effective collaboration. This is not only with the person with mental health problems but also from within an interprofessional working context. This chapter also demonstrates the importance for each professional to explore and understand the influences, philosophies and approaches that enhance and sustain such collaborations. By doing so, we can only benefit and enhance our practice and our work with people with mental health problems. This is a challenge to the traditional silo thinking that (unfortunately) still exists.

Chapter 11: Relationships and recovery
(Stephan D. Kirby)

The power behind successful recovery is the relationship between the person with the mental health problem and the mental health professional. In this chapter, Steve demonstrates how the traditional, paternalistic relationship is both damaging and infantilising, and the way forward, for the sake of the person with mental health problems, is the development of a collaborative dynamic therapeutic alliance. Within this chapter, he discusses a Model

of Therapeutic Alliances created following trans-European research that underpins the creation of such a dynamic partnership as they travel the road to recovery. It focuses on the fact that health care is a human activity and as such it is one where both parties grow and learn. The therapeutic alliance offers hope, the opportunity to grow and develop and, through its flexible power agenda, a mutual learning environment.

Chapter 12: Holistic care planning for recovery
(Devon Marston and Jenny Weinstein)

Devon and Jenny discuss how person-centred care planning must involve people with mental health problems and their families in all aspects of care planning. They clearly demonstrate, and advocate, that at every stage care planning must address all aspects of a person's life, not simply their medical condition. The adoption of a Recovery Approach to underpin planning care is essential. It is again through the use of the powerful vehicle of the personal narrative that the contributors demonstrate what is both bad and good with current mental health services and the way they are organised and delivered from the viewpoint of the people that matter most – the recipients of this service. A range of strategies are offered to ensure that recovery is fundamental to planning care.

Chapter 13: Recovery-orientated practice in education
(Mike Fleet)

Mike clearly shows how contemporary nurse education does not encourage, nor indeed prepare, the student mental health nurse to embrace the core values of recovery of self-determination and self-management, and hope and expectations. He demonstrates that there is a clear need for this to be rectified. By reminding us that recovery is not about cure, rather it is about reclaiming a satisfying and meaningful life, he proposes that we need to educate students to be able to develop hope-inspiring relationships. He shows how mental health nurse training curricula can, and should, move towards a clear and distinct recovery focus. The student mental health nurse should be taught how to use themselves and develop personal qualities that aid the recovery process of a person with mental health problems. There should also be a greater use of the person with mental health problems as a partner in this education, in everything from planning and delivering curriculum to mentoring and assessing students. He leaves us with the frank message that mental health nursing students do not enter the profession to

be agents of social control, yet that is the way they are perceived and what they ultimately end up becoming and that it is time to challenge mental health nurse education to remove the 'us' and 'them' and actively promote the 'we'.

Chapter 14: The recovery journey
(Stephan D. Kirby)

In this 'mini' chapter, Steve illustrates how the editors captured the major themes and concepts that influenced and underpinned this text. A visual, and annotated, representation (The Recovery Journey) of these is offered to the reader as a way to understand the recovery process (as we see it). In this, our variant, the recovery journey, has three major domains (which also form the frame for this book): 'Survive', 'Manage' and 'Thrive'. This then describes the various phases of the recovery process and descriptions of the experiences that the person with mental health problems could (or does) encounter at each phase are offered. It shows the journey from mental health crisis to mental health recovery, one which we hope will be beneficial to, and aid the reader in their endeavours, be they practitioner, academic or a person with mental health problems or their carer.

Chapter 15: Conclusions: reflection on the future
(Stephan D. Kirby, Mike Wren and Angela Hall)

And…the conclusions draws together the major issues and themes of the text and leaves the reader (hopefully) with food for thought in their own Recovery practices.

   Now we have introduced the individual chapters we would like, for one last time, to reacquaint you to the questions from the end of our last edition and at the start of this one. We kindly ask that, as you engage with this book (in whichever way suits you best, either submerging yourself or dipping your toes), you bear these in mind and then you can decide whether, or not, we have answered them effectively.

> *How different would services look if their primary focus was to enable people to use and develop their skills, make the most of their assets, and pursue their aspirations?;*

> *Would this not change, for the better, the experience of using services, and the relationship between workers, and those whom we serve?* (Repper & Perkins, 2003:11).

References

Anthony, W.A. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, **16**, 11–23.

Appleby, L. (2007) *Breaking Down Barriers: The Clinical Case for Change*. Department of Health, London.

Australian Government (2003) *Australian Health Ministers National Mental Health Plan, 2003–2008*. Australian Government, Canberra (www.mentalhealth.gov.au).

Barker, P.J. (2001) The Tidal Model: developing an empowering, person centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, **8**, 233–240.

Barnes, M. & Bowl, R. (2001) *Taking Over the Asylum: Empowerment and Mental Health*. Palgrave, Basingstoke.

Coleman, R. (1999) *Recovery: An Alien Concept*. Handsell, Gloucester.

Davidson, L. (2008) *Recovery: Concepts and Application*. Devon Recovery Group. Sainsbury Centre for Mental Health, London (www.scmh.org.uk).

Department of Health (DoH) (1983) *The Mental Health Act 1983*. Department of Health, London.

Department of Health (2001) *The Expert Patient*. Department of Health, London.

Department of Health (2006) *Our Health, Our Care, Our Say*. Department of Health, London (www.dh.gov.uk/en/index.htm).

Department of Health (2007) *Commissioning Framework for Health and Well-being*. Department of Health, London (www.dh.gov.uk/en/index.htm).

Department of Health and Human Services (2003) *Achieving the Promise: Transforming Mental Health Care in America. President's New Freedom Commission on Mental Health*, Pub no. SMA-03-3832. Department of Health and Human Services, Rockville.

Hafford-Letchfield, T. (2009) *Management and Organisations in Social Work*, Transforming Social Work Practice Series, 2nd edn. Learning Matters, Exeter.

Kaplan, G. (1964) *Principles of Preventative Psychiatry*. Tavistock, London.

Kirby, S.D. (2001) The development of a conceptual framework of therapeutic alliance in psychiatric (nursing) care delivery. In: *Forensic Mental Health: Working with the Mentally Ill Offender* (eds G. Landsberg & A. Smiley). pp. 25:1–25:8. Civic Research Institute, Kingston.

Kirby, S.D. & Cross, D.J. (2002) Socially constructed narrative intervention: a foundation for therapeutic alliances. In: *Therapeutic Interventions for Forensic Mental Health Nurses* (eds A. Kettles, P. Woods & M. Collins). pp. 187–205. Jessica Kingsley Publishers, London.

Larsen, J.A. (2004) Finding meaning in first episode psychosis: experience, agency and the cultural repertoire. *Medical Anthropology Quarterly*, **18**, 447–471.

Mental Health Commission (1998) *Blueprint for Mental Health Services in New Zealand*. Mental Health Commission, Wellington.

Mental Health Commission (2005) *A Vision for a Recovery Model in Irish Mental Health Services*. Mental Health Commission, Dublin.

Repper, J. & Perkins, R. (2003) *Social Inclusion and Recovery: A Model for Mental Health Practice*. Elsevier Health Sciences, Edinburgh.

Rogers, A. & Pilgrim, D. (2010) *A Sociology of Mental Health and Illness*, 4th edn. McGraw-Hill Education, Maidenhead.

Romme, M. & Escher, S. (1993) *Accepting Voices*. MIND Publications, London.

Saleebey, D. (2009) *The Strengths Perspective in Social Work Practice*, 4th edn. Allyn & Bacon, Boston.

Scotland Government (2006) *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland* [Online]. Available at www.scotland.gov.uk/Publications/2006/04/18164814/0. Accessed on April 30, 2013.

Shepherd, G., Boardman, J. & Slade, M. (2008) *Making Recovery a Reality*. Sainsbury Centre for Mental Health, London.

Watkins, P. (2001) *Mental Health Nursing: The Art of Compassionate Care*. Butterworth-Heinemann, London.

White, M. & Epston, D. (1990) *Narrative Means to Therapeutic Ends*. Norton, New York.