College of Psychiatrists of Ireland

Wisdom • Learning • Compassion

Recovery: Supporting Personal Recovery- The Role of the Psychiatrist

Position Paper

Approved by Council
September 2019

Contents

EXECUTIVE SUMMARY

The College has for some time recognised the importance of the personal recovery approach as one of the most significant developments in health and social care policy in recent decades. Although there has been greater awareness of the importance of person-centred care and service user and carer input to policy in Ireland, the progress in actual service development towards a greater recovery focus has not matched pace. Similarly, whereas support by professionals and services for personal recovery is mandated by policy and regulatory requirements the development of professional practice in this area has been limited by a number of factors including individual psychiatrists' knowledge and relevant skills in addition to systemic barriers such as a number of legacy issues, conflicting priorities and resource constraints. It is timely therefore that a position paper is published to provide practical guidance to College members on the recovery approach and to support psychiatrists in Ireland to address the challenges and benefits of recovery- oriented practice.

Recovery oriented practice is consistent with the guiding values of psychiatry, it is in keeping with developments in the field of medicine generally and is firmly based on the evidence for a range of interventions. Furthermore, recovery- oriented practice is more professionally fulfilling and offers psychiatrists a means to address historical inequalities in healthcare and to provide leadership for more person centred care in medicine.

Two particular considerations arising from this approach are how can psychiatric practice move beyond a focus on clinical priorities to fully support patients recovering the life they choose (a clarification of the purpose of our work) and developing the necessary ways of working with the patients we support (a new type of working relationship). The delivery of recovery- oriented practice has implications also for the health systems in which we work and in how psychiatrists exercise leadership in clinical teams, collaborate with other disciplines and in how we share our learning within the wider mental health service. Whereas the psychiatrist's specialist medical skills in assessment, formulation, diagnosis and treatment remain essential, recovery- oriented psychiatric practice requires a change to ways of working alongside people who use services and others to support patients to get on with living.

Key Principles

The paper considers the principles underpinning personal recovery and the social and policy context of the personal recovery approach to modern mental health care and offers conceptual and practical guidance for recovery oriented psychiatric practice. Such practice is based on the following key principles:

- Applying psychiatric expertise in support of the patient's personally defined needs and goals.
- Providing treatments as tools to achieve a hopeful and satisfying life for the person even in the presence of ongoing symptoms.
- Building on the patient's individual strengths and ability to manage their own condition.
- Co—producing care and support through collaborative decision making about treatment.
- Partnerships with patients, family members and carers to support community reintegration and meaningful roles in society.
- Advocating on behalf of people with mental health needs and their families and carers.
- Contributing our skills in education and research in partnership with service users in order to improve understanding, training, and research methodology relevant to the personal recovery paradigm.

Key Recommendations - Summary

1. **Values and Principle**:

- Psychiatrists to inform themselves of the origins and guiding values of recovery oriented practice and of recovery principles in keeping with good professional practice and the College's guidelines and regulations in relation to ethics and reflective practice.

2. Recovery Oriented Practice Development

- Recovery oriented psychiatric practice to be strengthened through personal reflection and reflective practice and participation in training activities, recovery college activity and the use of patient narratives.

- Recovery oriented psychiatric practice development to prioritise strengths-based approaches, shared decision making, collaborative care, self-management support, personal recovery care planning, socially inclusive approaches, amongst others.

- Recovery oriented psychiatric practice development to take particular account of peer support work, supported employment and housing support, amongst others.

3. Service Development:

- Recovery oriented psychiatric practice to be strengthened in collaboration with interdisciplinary mental health team members by means of participation in local and national quality improvement initiatives to support recovery.

- It is recommended that the College continues to promote recovery oriented practice, to advocate for the necessary resources in services and to address societal and whole mental health service change to promote the development of more recovery focused services.

4. **Training and Continuous Professional Development:**

- It is recommended that psychiatrists and psychiatric trainees avail of training opportunities in their local services and opportunities for reflective practice and peer educational group activities.

- It is recommended that continuous professional development and undergraduate and postgraduate psychiatric education is informed by best evidence based practice and the relevant national guidance relevant to recovery oriented practice.

- It is recommended that the College supports the delivery of comprehensive educational and practice development materials and guidance including at the undergraduate level.

- It is recommended that educational and practice development activities should incorporate the voice of the service user and carers through for example, the inclusion of the College REFOCUS committee (Recovery Experience Forum of Carers and Users of Services) members and contributions.

- It is recommended that the College supports the development of further guidance on recovery focused practice relevant to each area of psychiatry subspecialty practice including child and adolescent psychiatry, psychiatry of later life, forensic psychiatry, addiction and intellectual disability.

5. Research:

- It is recommended that the College engages with appropriate academic partners and service user and careers representatives in the development of guidance for personal recovery research methodologies.

Practical Steps - How can the Psychiatrist Practice in a Recovery Focused Way - Summary

- **Welcoming Environments**
    - **Engagement & Therapeutic Alliance**
- **Person Centred Care - Biopsychosocial Model**
    - **Patient Narratives & Reflective Practice**
- **Shared Decision Making (SDM**
    - Using Medication
- **Self Management Support**
    - Transforming the outpatient clinic to provide self- management support
- **Recovery Care Planning**
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- **Strengths based approach**
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- **Working with Peer Support**
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- **Recovery Colleges and Co-Production**
    - **Recovery in Practice: Recovery education in the National Forensic Mental Health Service**
    - **EOLAS as an example of Co-production**
- **Supported Employment**
    - IPS Model - **Integrating Employment and mental health supports**

ACKNOWLEDGEMENTS

This paper was developed with the assistance of College members and staff supported by a number of HSE employees and volunteers involved in the Advancing Recovery in Ireland programme. The content of the paper is based for the most part on the content of three workshop events hosted by the College and accessible to all members in three locations- Dublin, Limerick and Athlone between February and April, 2018. Additional written and verbal feedback was received from a number of Faculties and the Refocus committee and from individual members in 2018. Further refinement of the paper was carried out by a College working group in 2019.

The College wishes to acknowledge the support of the HSE which greatly facilitated the development of this paper- particular thanks is offered to Mr Tony Leahy and to the following Advancing Recovery in Ireland personnel for their time and commitment in preparing workshop events, facilitation of group discussion and in the collation of feedback - Ms Catherine Brogan, Ms Gina Delaney, Mrs Margaret Sweeney. Thanks are also due to the College Refocus group, Ms Andrea Ryder (Manager College Communications, Policy and External affairs), the many members who actively contributed to group discussion and provided faculty feedback and individual comments. We are grateful also to the following speakers who guided workshop discussions: Dr Miriam Kennedy, Dr Philip Dodd, Dr Marina Bowe, Dr John Hillery, Dr Dominic Fannon, Mr Michael Ryan, Professor Julie Repper and members of the working group: Dr Anne Jeffers, Dr Marian Bowe, Dr Dominic Fannon, Dr Eithne Foley, Dr Stephen Monks, Ms Andrea Ryder.

Recovery Oriented Practice At A Glance

Recovery Oriented Practice is:

- Strong Therapeutic Alliance- '*Practical, Hopeful and Helpful*'
- Strengths based
- Shared decision making
- Self -Management Support
- Personal Recovery Care Planning
- Working with peer support
- Co-Production
- Social inclusion- Housing First, Supporting Employment

"Developing recovery-oriented practice is not so much about an additional or supplementary agenda as about getting the basics right. It is about refocusing the conceptual compass guiding all practice and service development so as to be fundamentally oriented on enabling outcomes valued by the people we seek to serve"

(Roberts & Boardman, 2013, p 43).

Quick Guide to Recovery Oriented Practice:

After each interaction with someone, reflect on whether or not you were supporting their recovery and ask yourself:

Did I

- actively listen to help the person to make sense of their mental health problems?
- help the person identify and prioritise their personal goals for recovery (not professional goals)?
- demonstrate a belief in the person's existing strengths and resources in relation to the pursuit of these goals?
- identify examples from my own lived experience, or that of other service users, which inspires and validates their hopes?
- pay particular attention to the importance of goals which take the person out of the 'sick role' and enable them actively to contribute to the lives of others?
- identify non mental health resources- friends, contacts, organisations- relevant to the achievement of their goals?
- encourage the person's self-management of their mental health problems?
- discuss what the person wants in terms of therapeutic interventions, for example psychological treatments, alternative therapies, joint crisis planning, respecting their wishes wherever possible?
- behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together, indicating a willingness to 'go the extra mile'?
- while accepting that the future is uncertain and setbacks will happen, continue to express support for the possibility of achieving these self- defined goals- maintaining hope and positive expectations?

(Shepherd, 2008)

"[Recovery focused psychiatric practice] identifies and builds upon each individual's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive, sense of membership in the broader community" *(Davidson et al. 2005)*

INTRODUCTION

Personal recovery refers to a process of change through which individuals improve their health and wellbeing, live a self-directed life and strive to reach their full potential. The recovery approach to mental health care and service delivery has been adopted as a key organising principle of national (New Zealand, 1998; England, 2001; Ireland, 2006, Scotland, 2006; South Africa, 2013; India, 2014) and federal mental health policies (United States, 2003; Australia, 2003) across the globe and by the World Health Organisation. The College has consistently advocated for mental health services in Ireland to be based on the personal recovery approach including a system of care which ensures access to assessment and intervention with an appropriate menu of treatments available to patients based on need. Just some examples highlighting the importance of this approach include the work of the College's Refocus Group, with the publication of 'On The Road to Recovery' (College of Psychiatrists of Ireland, 2013), nurturing of strong collaborative links with service user and family member and carer advocacy groups and contributions to national policy development amongst other measures. See Box 1.1: Refocus.

In Ireland, as in other jurisdictions a transformation has occurred in mental health care involving deinstitutionalisation and a shift to community psychiatry along with the acknowledgement of the importance of social factors such as homelessness, unemployment and poverty to both physical and mental healthcare outcomes (e.g. Jetten et al, 2012).

1.1 REFOCUS Recovery Experience Forum of Carers and Users of Services

REFOCUS is made up of people with experience of the mental health services – patients/service users, family members / carers and psychiatrists. The Committee's role is to inform and influence all aspects of the College business objectives particularly the training experience of young future psychiatrists and identifying ways to improve the mental health services with psychiatrist members.

REFOCUS originally formed in late 2011 with 10 people with experience of the mental health services, 10 of their family members and carers, and one psychiatrist. Members give their time to work with the College in improving training of psychiatrists, and in identifying ways to improve the mental health services. The committee now comprises an equal number of people with experience of the services, service users/patients, family members/ carers and psychiatrists. The work and objectives have broadened to encompass on going education and training of psychiatrists.

Through a series of regular meetings and sub group meetings REFOCUS debates issues, writes papers, presents at conferences and is invited to events of external bodies where the voice of those who use the mental health services and their family members/carers are found to be invaluable.

REFOCUS Papers look specifically at the role of the carer and/or service user such as *Who Cares? Listening to the needs and experiences of carers of people with mental illness* ***and*** *On the One Road to Recovery* ***which both aim to raise awareness of their specific needs. College faculties and Council have had an opportunity to advise and comment on the papers, but the content of all REFOCUS papers are solely the responsibility of the whole group. Council members have welcomed REFOCUS papers as a means of facilitating more dialogue between College members and both users of their services and their family members/carers.***

There has also been a fundamental shift in approaches to chronic illness and disability in recent years whereby social inclusion is emphasised along with more traditional biomedical approaches to care. A change in policy focus away from curative mental health care to mental health promotion and early detection has taken place with greater attention towards patient empowerment and reducing stigma in higher income countries (Knapp, 2008). Providing socially inclusive services is therefore fundamental to contemporary psychiatric practice. At the same time there has been a growing recognition of the need to rebalance biomedical approaches across medicine where the predominance of technical applications has resulted in a devaluing of "*human understanding, kindness, emotional awareness and talking …[in] doctoring*" (Gillon, 2013, page 106). This negative impact of an increasingly biomedical approach to the detriment of the human context of care has been noted by psychiatrists in recent decades (e.g. Engel, 1992; Campling, 2015).

"From the perspective of the individual, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self.

……

Recovery is not synonymous with cure….."

(World Health Organisation, 2013)

Current national mental health policy encapsulates this reorientation of health care while the mental health regulator details the parameters of a recovery oriented mental health service as being a mental health service that emphasises the expectation of recovery from mental ill health and promotes both enhanced self-management for mental health service users and the development of services which facilitate the individual's personal journey towards recovery (Mental Health Commission, 2005); (see Box 2).

1.2

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 *(page 9)*

Interventions should be aimed at maximising recovery from mental illness, and building on the resources within service users and within their immediate social networks to allow them to achieve meaningful integration and participation in community life *(page 8)*

(A Vision for Change: Report of the expert group on Mental Health Policy". Department of Health & Children, 2006)

Elements of a Recovery Based Mental Health Service

- *Training in Recovery Principles*
- *Individualised Self-Management Plans*
- *Optimism about Recovery*
- *Peer Support & Community Resources Integral To Recovery Plans*
- *Health Professional Work to Reduce Clinical Distance*
- *Services Incorporate the Expert Knowledge of Service Users*
- *Equality of Access to Mainstream Services- Housing, Education, Health and Social Services*
- *Psychosocial Research to capture more of the complex multilevel data which comprises the experience of mental illness and recovery.*

(Adapted from 'A Vision for a Recovery Model in Irish Mental Health Services'. Mental Health Commission, 2005)

"The framework will ensure a consistent, good quality, evidence based, co-produced and clinically excellent approach to establishing recovery focused services in Ireland. It provides an overview and definition of what recovery oriented service means, and the key principles, actions and measures that underpin such a service in an Irish context."

(A National Framework for Recovery in Mental Health, Health Service Executive, 2018)

The centrality of a recovery approach is further reinforced by a range of quality standards applicable to mental health services and psychiatric practice, for example The Judgement Support Framework (Mental Health Commission, 2017) and Best Practice Guidance for Mental Health Services (HSE, 2017) while the strategic importance of the reorientation of mental health care delivery towards recovery is evidenced by a number of national initiatives such as Advancing Recovery in Ireland, Enhancing Teamwork, Eolas and the development of the Office of Mental Health Engagement. More recently a national framework designed to guide the implementation of recovery-oriented services in Ireland- A National Framework for Recovery in Mental Health (HSE, 2018) has been developed- see Box 2.

THE POSITION

The College shares the World Health Organisation's vision of "*a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally- appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatisation and discrimination*" (World Health Organisation, 2013).

"mental health is a state of wellbeing in which an individual can realise his or her own potential, cope with the normal stresses of life, work productively and make a contribution to the community" (WHO, 2013).

The College acknowledges that the development and delivery of recovery focused mental health care has implications for the design and organisation of services, for individual psychiatrists' practice and in terms of education and continuous professional development of the College membership. The College's view's on recovery are outlined in the following with recommendations for practice development in the next section.

What is Recovery?

The term 'recovery' as used in the mental health context has multiple meanings, arising from different theoretical perspectives. A critical distinction is made between clinical and personal recovery where clinical recovery refers to a reduction or elimination of clinical symptoms and is defined and measured by health professionals using criteria developed by researchers and clinicians. For example, Liberman & Kopelwicz (2002) define clinical recovery as '*Full symptom remission, full or part time work/ education, independent living without supervision by informal carers, having friends with whom activities can be shared sustained for a period of 2 years".* In contrast to a medical conceptualisation (focused on reducing or eliminating clinical symptoms), recovery-focused mental health care adopts a different focus on enabling people to realise their own potential to manage their condition so that they can live a life that they value even in the presence of clinical symptoms (Davidson et al., 2010). In this respect, the concept of recovery may be more consistent with a formulation of mental wellbeing rather than mental disorder or in terms of 'salutogenesis rather than pathogenesis' (Bailey & Williams, 2013). The recovery approach focuses therefore on what a person can achieve while living with a mental illness. Psychiatrists have described it succinctly as '*Recovery involves living as well as possible*' (SLAM, 2010) or '*Recovery refers to people living as well as they are able*' (Bailey & Williams, 2013), to be supported by mental health professionals adopting an holistic attitude and using principles of health promotion and prevention along with our traditional treatment and rehabilitation skills.

"A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself."

(Anthony, 1993).

"Recovery refers to people living as well as they are able. But it also takes us beyond returning to how we were before we became unwell to our developing new meaning and purposes in our lives as we grow beyond the effects of our health problems." (Bailey & Williams, 2013).

What is the Evidence to support Recovery?

Personal recovery represents a complex multidimensional construct comparable to concepts of mental health and illness which are not amenable to simplistic measurement (Anthony, 1993, Davidson & Roe, 2007). As in the physical healthcare field generally there has been a growing recognition of the importance of the values base to the practice of medicine acknowledging the need for effective evidence-based interventions which are also meaningful to the patient (Brown et al, 2005). A key challenge in recovery research has been how to devise methodologies which reliably capture personally defined outcomes rather than the exclusive measurement of symptom levels or service utilisation. Outcome measures determined by clinicians (such as Lieberman & Kopelwicz, 2002) do not necessarily reflect the recovery outcomes of patients (Andresen et al 2003). As a subjective experience recovery is variously defined by service users as a process and an outcome and empirical investigation has involved a range of approaches in determining how best to evaluate processes central to both clinical and social recovery and the effectiveness and economic impact of specific recovery promoting interventions (e.g. Bellack & Drapalski, 2012; Jose et al, 2015). This is similar to the challenges in the design, delivery and evaluation of complex mental health interventions generally (e.g. Thornicroft & Tansella, 2004).

Historically, many psychiatrists and other healthcare professionals have taken a pessimistic view of the prognosis for schizophrenia, regarding it as a severe, intractable and often deteriorating lifelong illness. This negative view has failed to find confirmation from long-term follow-up studies, which have demonstrated considerable variations in long-term outcome. …. It should also be noted that some people who never experience complete recovery from their experiences nonetheless manage to sustain an acceptable quality of life if given adequate support and help. (National Institute for health and Clinical Excellence. NICE clinical guideline 178, 2014)

Whereas previously there has been an unrealistically pessimistic estimation of the potential for recovery in severe mental disorders- a so called 'chronicity paradigm' (Harrison, et al. 2001) - this has now been balanced by more evidence based considerations. The long term outcome for people with severe mental disorders is better than is often believed, for example people with schizophrenia (e.g. Jobe & Harrow, 2005), although our understanding of the processes involved is limited (Velthorst et al., 2017). It has been argued that a greater part of poor real world functioning may be attributable to the impacts of negative symptoms and cognitive deficits (Davidson & McGlashan, 1997), the lack of access to meaningful activity such as prolonged involuntary unemployment (Leff & Warner, 2006) or social and financial impoverishment (Zipursky et al., 2013). It has also been proposed that a significant impediment to good recovery outcomes is due to a 'treatment barrier' in the form of habitually low expectations on the part of

mental health professionals regarding the capacity of patients to exercise control and autonomy in relation to their own recovery (Warner, 1994). This has been borne out by the experience of the College Refocus group in relation to medication where for example, there may be a tendency to overestimate the role of medication in the management of clinical symptoms on the part of psychiatrists who do not believe in the possibility that patients can self-manage. Consequently there is less open discussion on how those symptoms can be managed through alternative supports (College of Psychiatrists of Ireland, 2013). While psychotropic treatment is invaluable for many patients its utility in improving real world functioning is unclear (Meltzer, 2009) while longer term follow-up of treatment outcomes in psychosis suggest that many patients achieve a good long term recovery without medication or with low-dose treatment (McGorry et al, 2013).

"... in the last two decades, we have made great strides in understanding mental illness. Gone are the ideological disputes of previous years. Research has instead shown that both biological and social factors are involved, and we have learned that a diagnosis of schizophrenia does not predict inevitable decline." *(Professor Sir Robin Murray on behalf of the Schizophrenia Commission, UK 2012).*

It is now widely accepted that evidence based psychosocial interventions improve patient outcome and support personal recovery in long term mental disorders (Schizophrenia Commission, 2012), although access to evidence based interventions is often limited (Murray et al, 2016). When such interventions are applied there is good evidence that they support patients to realise personal goals. For example, cognitive behavioural therapy, cognitive remediation, family education and supported employment (Mueser et al, 2013). The most direct evidence for personal recovery support comes from interventions which address the fundamental processes isolated in a systematic review - the CHIME framework (Leamy et al, 2011). This has identified five central processes which are key to individuals' personal recovery- connectedness, hope and optimism, identity, meaning and purpose and employment- each of which has empirical evidence to support it based on experimental investigations (Slade et al, 2014). These include peer support workers (Pitt et al, 2013), advance directives (Kisely, & Campbell 2009), Wellness Recovery Action Plan (WRAP) (Cook et al, 2012), illness management and recovery (Fardig et al, 2011), recovery promoting relationships (Slade et al, 2015), strengths based models (Tse et al, 2016), self-management through education programmes (Foster et al, 2007), Individual Placement and Support (IPS) (Bond et al, 2016) and supported housing (Larimer et al, 2009).

However, even though these interventions are known to be effective, recovery ideas are complex and the implications for practice continue to be debated with tensions remaining, for example in relation to the role of professional expertise and how to balance patient choice and social expectations (e.g. Hibbard & Gilburt, 2014; Slade & Longden, 2015). There is also an identified need for an integrated approach to ensure comprehensive delivery across a mental health service and the wider health system (LeBoutillier et al, 2011; Kidd et al, 2014). A number of recovery oriented practice approaches are illustrated in the following pages and more details are provided in the appendix- Useful resources at the end of this paper.

"People who see themselves solely as a patient conform to an image of incapacity and worthlessness, becoming more socially withdrawn and adopting a disabled role. As a result,

their symptoms may persist and they may become dependent on treatment providers and others" *(Warner et al. 1994)*

What is Recovery Oriented Practice?

Historically, the practice of psychiatry has been characterised by a focus on symptoms and functional deficits where treatment approaches are used for the removal or reduction of symptoms and the resolution of impairments in order to achieve clinical recovery. In contrast, personal recovery, that is living a meaningful life even in the presence of ongoing symptoms, difficulties or functional impairments is not synonymous with cure and recovery is not a medical or psychiatric treatment though medical treatment is often a part of an individual's recovery process. A recovery orientation therefore can be seen to counteract an historical paternalistic approach which is recognised as inconsistent with current psychiatric practice (Beauchamp & Childress, 2013) while still valuing the role of compassion and 'intelligent kindness' (Ballatt & Campling, 2011). One definition which encompasses these components is '[recovery oriented practice] *identifies and builds upon each individual's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive, sense of membership in the broader community"* (Davidson et al. 2005).

"While technical advances such as the development of biomarkers will potentially alter diagnosis and treatment, and digital technology will facilitate assessment of remote populations, the human elements of practice such as cultural sensitivity and the ability to form a strong therapeutic alliance with the patient will remain central."

(The WPA- Lancet Psychiatry Commission on the Future of Psychiatry, Bhugra et al. 2017, page 775).

The fundamental basis for recovery oriented practice falls within what have been characterised as 'the human elements of practice' including the nature of the therapeutic alliance (Bhugra et al, 2017). In the recovery context this refers to a relationship which is based on trust, empathy, compassion and respect and principles such as collaboration and partnership which guide all healing professions and are central to the practice of medicine. As well as being consistent with good ethical practice (e.g. Medical Council, 2016), recovery oriented practice is also in keeping with the College guidance on professional ethics. For example, '*Psychiatrists should work in collaboration with their patients, respecting their right to privacy, confidentiality, autonomy and self-determination*' (Principle 1.4; College of Psychiatrists of Ireland, 2019). Similarly, the College curriculum for basic and higher specialist training currently includes reference to recovery principles in the area of care planning.

"The core service requirements include: listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care; offering choice of treatment and therapies, and in terms of who provides care; and the use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise". *(WHO, 2013)*

Recovery Oriented Practice Guidelines

It is self evident that psychiatric practice is intrinsically more person focused rather than solely illness focused compared to other areas of medicine and the evidence demonstrates that our interpersonal behaviour with patients is part of the treatment (e.g. Priebe & McCabe, 2008). Recovery oriented practice builds on this strength of good psychiatric care by incorporating the lived experience of the patient and focusing on what is most relevant to the patient's life to improve the planning and delivery of treatment. The key practices implicated here were initially highlighted in the context of psychiatric rehabilitation approaches, namely 'person orientation', 'person involvement', 'self-determination/choice' and 'growth potential' (e.g. Farkas et al, 1989).

Early recovery oriented practice guidelines based on empirical research identified the importance of patient satisfaction and patient narratives, the provision of mental health information and the relevance of an empowering approach (e.g. Mountain & Shah, 2008). The latter noted that psychiatrists as '*Good doctors attend to the person as well as the illness…[and] use the best available evidence- the medical model- to promote hope, encourage self-management, maximise strengths, and support patients to rediscover meaning and purpose for themselves*' (page 244). It has been suggested that in order to clarify how best to promote recovery a distinction is made between 'recovery-promoting relationships' (that is the quality of the therapeutic relationship) and 'pro-recovery working practices' (meaning specific interventions which support of recovery) (Bird et al., 2011).

A range of recovery oriented practice guidelines are now available for psychiatrists, including recommended curricula to support this area of practice in the USA (American Psychiatric Association, 2012) and the UK (Royal College of Psychiatrists, 2018). Table 1 summarises the key knowledge areas and recovery oriented practice competencies which are consistent with good practice or supported by empirical evidence. The following sections consider aspects of the therapeutic relationship (engagement, person centred care, patient narratives and reflective practice) followed by details of specific pro-recovery working practices supported by empirical evidence along with examples in the current Irish context. See Table 1: Recovery Oriented Practice Knowledge, Skills.

Table 1:

Recovery Oriented Practice Knowledge & Skills				
Recovery for All: Hope, Agency and Opportunity in Psychiatry (2010)	Recovery to Practice Curriculum for Psychiatry (2012)	Becoming A Recovery Oriented Practitioner (2014)	Person - Centred Care; Implications for Training in Psychiatry (2018)	
Practices:	*Modules:*	*Knowledge/ Skills:*	*Curriculum/ Postgraduate training:*	
	Introduction to Recovery Oriented Care	Understanding of, Personal Reflection on Recovery	Person Centred Care, Personal Recovery, Reflective Practice, Patient Narratives and Core Skills and Values for Psychiatrists	
	Engagement and welcoming environment	Creating a hospitable and welcoming environment	*Relational Competencies:*	*Training Structures:*
Improving employment outcomes	Person centred planning and shared decision making	Supporting self-management	Shared decision making	Trainee involvement in recovery colleges
Empowerment	Peer supports in recovery	Building on strengths and working to personal goals	Self-directed support	Service users/ carers in training courses
Peer Support	Role of medication	Enabling self-direction and control	Co-production	Person centred training placements
Self-management	Health and wellness focused care	Working with peer support	Collaborative care	
	Developing living skills and natural supports	Recovery education for personal recovery	Support planning	
	Culturally appropriate care	Recovery oriented care planning		
	Trauma informed care	Developing natural supports and community participation		
South London and Maudsley & South West London and St Georges Trusts (2010)	*American Association for Community Psychiatry/ American Psychiatric Association. Recovery to Practice Curriculum for Psychiatry.*	*Roberts G, Boardman J. Becoming a recovery-oriented practitioner. Adv Psychiatry Treat. 2014;20:37–47*	*Person-Centred Training and Curriculum Scoping Group. Person-Centred Care: Implications for Training in Psychiatry. College Report CR215. RCPsych, 2018*	

Engagement and Welcoming Environments

The importance of the physical infrastructure and the emotional tone of the service environment is highlighted by many practice guidelines (e.g. Slade, 2009; Mental Health Commission, Canada, 2015; Australian Health Ministry, 2013). This makes intuitive sense in the context of patients when they first attend a mental health service and perhaps particularly in the case of ethnic or minority group or associated with other causes of stigmatisation. Unsurprisingly, this was also considered to be an importance practice element by psychiatrists participating in the discussions contributing to this document (Appendix 1). See Box: **Customer services approach- A Consultant Psychiatrist's Experience.**

2.1. Customer services approach- A Consultant Psychiatrist's Experience

Any good business approach will emphasise the importance for services to use a customers services approach – what does the customer want, where do they want it and how can we improve the customer experience. Unfortunately for patients using mental health services it does not always feel like this.

Best practice in psychiatry supports using a patient centred, bio-psychosocial approach while structural oorganisational changes may be required to ensure a consistent recovery focused approach. Access to services can often include a number of road blocks – the patient has to have the right form, be in the right place, have the right illness and go along with the plan the team has for them. If not, they are not welcome. Certainly, when resources are poor services have to be rationed and so teams strive to find the most efficient use of their time. True recovery focused mental health services need to be flexible enough to support patients who may be living quite chaotic lives. Reduced resources in CMHTs can lead to inflexible practices, with many obstacles placed to accessing care. The patients has to have the same form ….etc. In order to deliver a flexible, recovery focused approach CMHTs must be fully resourced and open to using a recovery approach. A personal recovery approach might include the following:

- As a service work with referrers to identify mutually agreeable referral protocols – ensure all referrers are aware of and agreeable to these referrals.
- Work with General Practitioners in identifying how to best support people who are in crisis, who need urgent specialist input and who need routine specialist input.
- Ensure referral protocols are compatible with national policies and international guidelines.
- Ask the question – 'Is this how I would like my family member to be treated?'
- Ensure all the team, including the non clinical staff, adopt a compassionate, empathic response to all patients.
- If a person misses an appointment, contact them by phone, leave an understanding compassionate message inviting them to another appointment the following week, or to contact the service earlier if needed. If they fail to contact by the following week, arrange for a healthcare professional, from the primary care or specialist team to visit them – patients treated with this respect respond well.

These approaches improve efficiency and will improve outcomes.

Person Centred Care- Bio-psychosocial Model

Recovery focused care shares many of the characteristics of person or patient centred care. Patient centred medicine has been characterised as '*Understanding the patient as a unique human being*' (Balint, 1969) and '*Seeing the person in the patient and delivering the sort of care you would like for your family and friends*' (Goodrich & Cornwell, 2008). Mead & Bower (2000) identify five core elements of person centred care ('*Bio-psychosocial Perspective', 'Seeing the patient as person', 'Sharing Power & Responsibility', 'Therapeutic Alliance*' and '*Doctor as Person*') which provide a useful frame of reference for recovery oriented practice. In addition to a bio-psychosocial perspective which underpins all contemporary psychiatric care the importance of collaboration between both parties - doctor and patient meeting as people in a joint partnership is strongly emphasised.

While all elements of this framework are relevant to understanding and developing recovery oriented practice the emphasis on the personhood of both patient and doctor is perhaps of particular interest. For example, personal reflection and reflective practice are integral to all recovery oriented practice guidelines and a core component of training in psychiatry in this country as evidenced by recent revisions of the curriculum. Furthermore there has been a growing realisation of the importance of patient narratives across all of medicine (e.g. Greenhalgh & Hurwitz, 1999) and in psychiatry where incorporating a fuller understanding of the patient experience can complement evidence based interventions (Roberts, 2000). Furthermore, the '*sharing power and responsibility*' element is also highly relevant to understanding and developing recovery oriented practice. For example it has been argued that the essential change which is required in order to achieve patient centred care is a change in the nature of the relationship between the patient and the service provider so that the balance of power is altered away from the professional who traditionally held authority and control and towards the patient who is empowered, in part through shared decision making (Gask and Coventry, 2012). This is reflected in recovery oriented practice guidelines in the areas of patient engagement and the relevant 'relational competencies' along with recommendations for changes to training structures such as a greater role for patients and carers in training and trainee involvement in recovery colleges (see table 1).

Shared Decision Making (SDM)

Systematic review evidence has demonstrated that shared decision making leads to a greater sense of control and hopefulness (Shrank et al, 2012), better medication concordance (Baker et al, 2013) and reduced need for seclusion (Health Foundation, UK, 2012). There is considerable evidence in support of this approach overall and a growing evidence base from controlled trials specific to mental health care such as the use of shared decision making and joint crisis planning (Henderson et al 2004; Duncan et al, 2010). Henderson et al (2004) have demonstrated that joint crisis planning reduces compulsory admission and associated service utilisation costs. There is a growing literature on SDM and online resources for a range of psychiatric disorders (e.g. Deegan, 2010) and guidance in relation to collaborative work with patients in relation to medication decisions (Roberts & Boardman, 2014; Slade, 2017). See Box: Practical steps for the psychiatrist to support shared decision making are (Wexler, 2012).

2.2 Practical steps for the psychiatrist to support shared decision making are (Wexler, 2012)

- Invite the patient to participate. *By offering an invitation, you are letting them know that they have choices and that their goals and concerns are an important part of the decision-making process*
- Present the options. *Before making an informed decision, patients need to know all the options available to them.*
- Provide information on benefits and risks. *Give balanced information. Use numbers rather than words when you can. Without them, patients tend to overestimate the benefits and underestimate the risk, and their expectations are less realistic. It's also important to check in with patients to make sure that they correctly understand the potential benefits and harms.*
- Help the patient evaluate the options based on their goals and concerns. *Patients may not be comfortable raising their personal goals and concerns for treatment. By actively inquiring, you are giving them permission to speak about what is important to them. Once you have elicited this information, you can help them look at their options based on their preferences.*
- Facilitate deliberation and decision-making. *Patients may not be ready to make a decision immediately. Probing for what else they need to know or do before they make the decision can be helpful. If they are ready to decide, you can help facilitate a final decision.*
- Assist with implementation. *Close the conversation by laying out the next steps for the patient.*

'Providers do not relinquish their professional accountability, but seek to empower people and their supporters by providing information and acting as a "coach" in shared decision making rather than as an "expert" who directs care'.

Mental Health Commission Canada (2015, page 79)

"I was on [medication] years when a doctor told me there were really good odds that I could stay well if I reduced it very slowly. I wanted to take those odds. Every time I discussed stopping medication with my psychiatrist he managed to convince me to stay on it. Eventually I came off it very slowly, but only told him after I stopped it, because I knew he would not agree. I have stayed well without it."

(On The Road to Recovery, 2013, page 12)

Self Management Support

It is notable that one of the commonest evidence based approaches to recovery oriented treatment is not actually administered by the psychiatrist at all in so far that supporting illness self management skills and competencies in the patient is achieved involving a process of increasing responsibility for patients 'that is gradual and individually negotiated, on an ongoing basis" (McCranie, 2015). These approaches involve moving away from a more traditional paternalistic stance to one of shared decision making through negotiated patient responsibility in a number of ways. One key practice change involves adopting a co-production approach which entails three core activities which can be applied to support recovery (Horne, 2013):

1. Changing consultations to create purposeful structured conversations that combine clinical expertise with patient driven goals and build networks of support.
2. Commissioning new services that provide more than medicine to complement clinical care by supporting long-term behaviour change, improving well-being and building social support networks.
3. Patients and professionals co-designing pathways that focus on long-term outcomes, recovery and prevention. (Quoted in Bailey & Williams, 2013).

See box 2.3. 'Transforming the outpatient clinic to provide self -management support'

2.3 Transforming the outpatient clinic to provide self management support

As the Consultant on the team it is our role to identify an individual's diagnosis and treatment options. Other members of the multidisciplinary team can offer invaluable inputs but in practice most Consultants end up seeing a large number of patients that no-one else on the team sees. The outpatient clinic becomes a very effective way of seeing a large number of patients in a short period of time. Over the years we get to know patients very well, we become adept at greeting the person, escorting them to our room, listening to how they are managing, reviewing the management, explaining the changes required and escorting the person out again – all in less than 15 minutes! The patient leaves very satisfied for the next six to eight weeks and the doctor at the end of a clinic has a great sense of satisfaction that so many patients have been seen in a few hours. But then as more and more patients are referred , the clinics become longer and longer, junior doctors, instead of learning from the Consultant, take on more patients themselves, they try to see people in 15 minutes, but they don't have the clinical experience, or the knowledge of the patients and it does not work as well. Patients refuse to see the junior doctors – instead everyone wants to see the Consultant.

In embracing the Recovery approach my multidisciplinary team came up with a solution – I would stop seeing patients in the out patient clinic – instead all review patients would have a key worker from any discipline in the team. The key worker could review them more often and for longer sessions – and the team would discuss each person's progress. On announcing this to the patients many were wary, used to seeing the Consultant, but most agreed to try it out. One woman initially refused to change, insisting I knew her over the years and seeing me for 15 minutes every 2 months was keeping her well. We persuaded her to try it for 3 months, agreeing to see a nurse every 2 weeks in the meantime and then review by myself in 3 months time – if she then wished to change back she could. Over the 3 months I was hearing from the nurse how this woman was progressing. At the 3 month review she entered the office saying "You should have done this years ago". Where I used to focus on medication or discussing psychological factors in her life the nurse focussed on her self-management, how she could help herself. Within another few months she was successfully discharged from the service, with an agreement she could return if needed. This story was repeated in many other cases. I had expected the change to make my life easier – I had not expected the difference it would make to patients. I realised how the traditional approach had all of us, patients included, playing a particular role – it is only when the full team can step back and reflect on what is happening that change can occur.

After a short while I only saw patients in the clinic with their key worker. I continued to focus on the clinical aspects, but patients benefitted from a full team approach. We discharged people more quickly and worked closely with GPs in the area, ensuring all were on board with the new approach. Patients and staff found it rewarding.

Practical steps for the psychiatrist to support self management are:

1. To focus care planning on 'wellness goals' and not just symptom control. This promotes patient autonomy and acknowledges the patient's superior knowledge based on their own lived experience and making explicit that the overriding purpose of the healthcare system is to support the achievement of social goals.

2. To support the patient taking back control over problems, the services they receive and ultimately of their lives where the primary goal in treatment is to promote self-management, support self- determination provide choice and greater responsibility on the part of the service user. This can be achieved using the following simple techniques:

   a.Agenda setting At the start of the consultation, the practitioner and the person they are supporting agree the health issues they want to explore and the problems they want to solve. It signals from the beginning that the person with a long term condition is an active partner in their own care and that both parties will take a partnership approach.

   b.Goal setting and action planning: In this stage of the appointment, the health professional or health coach supports the person to identify the goal they want to work towards and to break this down into small achievable actions.

3. **Goal follow up:** Crucial elements at this stage include the opportunity to develop problem solving skills and explore solutions to barriers and receive positive affirmation of progress and effort. To support peer facilitation, that is exposure to other service users or peer workers who can contribute their lived experience of managing mental illness; this provides more effective role modelling of coping with illness that the professional's input alone.

Recovery Care Planning

The quality and effectiveness of the care planning process are likely to be amongst the strongest indicators of personal recovery support while at the same time the most sensitive to non-clinical factors in care such as the local services policies regarding documentation, care co-ordination and risk assessment (Roberts & Boardman, 2014). Although many models and guidance documents are available the challenge is to ensure that recovery oriented practices, particularly self-management support are incorporated, an element that is found to be most challenging for the practitioner in the inpatient setting (e.g. Chen et al, 2013) and in the area of positive risk taking (e.g. Gaffey et al, 2016). One of the most widely used frameworks to support self management is the Wellness Recovery Action Plan (Copeland, 1999) for which there is a robust evidence base This tool has been shown to be effective in terms of reduced symptomatology, increased quality of life and greater hopefulness in a large randomised controlled trial in the USA (Cook et al, 2012). In essence, a 'self management tool' the WRAP explicitly places the patient at the centre of the care system and supports the patient to identify strategies to maintain their daily wellbeing, to become aware of illness precipitants and to anticipate and prepare for future challenges including relapse.

Used effectively, this process rebalances the conventional doctor-patient relationship by placing the service user's perspective at the centre of the treatment and care planning process (Smith et al, 2011, page 7).

The application and valuation of WRAP in Irish services has shown its acceptability and effectiveness (Higgins et al, 2010). See box 2.4. 'Self management planning using WRAP' for an illustration of how this has been achieved in a general adult psychiatry setting in Ireland.

2.4 Self-Management Planning using WRAP

There is good evidence that for any chronic disease self-management plans will improve outcomes. All international guidelines and national policies identify the need for self-management and care planning for Psychosis, Bipolar Affective Disorder, Recurrent Depression and Anxiety disorders.

The Wellness recovery action plan (WRAP)uses the principles of Recovery in supporting patients to develop self-management plans. The patient identifies how they are when they are well and what behaviour and signs indicate they are relapsing. They identify any triggers to relapse, and what they need to do if triggers are present; they identify early warning signs and signs of relapse, and what needs to be done at each phase. They specify a crisis plan, outline the signs of a crisis and how they would like to be supported during that crisis. They can also work on a post crisis plan, reviewing their management when they have been through a crisis. Teams that focus on personal recovery give patients an opportunity to complete WRAP plans, either as an individual or in group setting. WRAP planning becomes integral to good management and many team members develop their own personal WRAP. They work!

Strengths Based Approach

A key recovery oriented practice is the identification and inclusion of patients inherent knowledge and strengths as a means to support a sense of hope and control over their conditions and lives and to enable opportunities for a meaningful life (Perkins & Repper, 2003; Shepherd, 2010). A strengths based approach seeks to identify the person's qualities and competencies and their existing resources (family, friends, neighbours, local opportunities) in order to acknowledge personal achievements which they often struggle to identify, and as a means to build up skills and strategies to further their personal life goals (ImROC business case). This approach has been shown to reduce hospitalisation rates, enhance occupational functioning and increase hopefulness (Tse et al, 2016). A related method is the use of the 'coaching' model (Bora et al 2010) where the practitioner adopts a facilitating role which highlights the service user's responsibilities to commit to action. In this sense the role of the professional is to be 'on tap, not on top' (Perkins & Repper, 2003). There is now emerging evidence for the effectiveness of coaching in relation to supporting recovery in the mental health setting including cost benefits achieved through improved social functioning (Health Foundation, UK, 2012; Slade et al, 2015). See Box 2.5. Coaching Approaches

2.5 Coaching Approaches

- Core coaching competencies are Co-production, Communication Skills, Facilitating Learning
- Application of the Wheel of Life (Mind Tools 2010) and the GROW framework (Whitmore 2002)
- Active, intuitive listening
- Skilful and outcome-focused questioning
- Identifying moving-towards and moving-away values and values that could be in conflict
- Aligning core values during goal-setting
- Awareness of basic human needs and the means used to meet them
- Re-framing meanings of experiences
- Exploring and/or jointly challenging safety behaviours or limiting beliefs
- Creating awareness

(Adapted from Bora et al, 2010) ***Working with peer support***

"Peer workers have significantly changed the recovery focus of our team, they challenge the way we talk about people from a problem and diagnosis focus to one of strengths and possibilities"

(Politt et al., 2012).

The employment of peer workers, that is individuals with experience of mental illness and recovery in Irish mental health services is one of the most visible signs of support for recovery implementation and is strongly supported by existing evidence including randomised controlled trials (Pitt, et al., 2013). Peer support has been defined as *"offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations"* (Mead *et al.* , 2001). Key elements of Peer Support in mental health include that it is built on shared personal experience and empathy, it focuses on an individual's strengths not weaknesses, and works towards the individual's wellbeing and recovery. The introduction of peer support to a service needs to be part of more comprehensive service development which includes clinical team preparation in order to be effective (McLean et al, 2009).

The practical steps which can be taken by the psychiatrist to support recovery implementation through peer support have been summarised by Repper (2013). The key steps include:

- Engage with colleagues and teams with peer support already integrated into their service.
- Consider the nature and role of peer support and how it differs from other roles in your team (see Appendix Useful Resources)
- Consider the different sorts of expertise within the team
- Honestly discuss hopes, fears and concerns within your team

- Develop a sense of collective ownership by coming together to think about the relative roles and responsibilities of peer workers and other team members in their own particular context
- Provide reassurance from senior managers that there is a commitment to these developments from the top and that they will respond to questions and concerns.

See BOX 2.6. 'Peer Support- Experiences of a Peer Support Worker and Consultant Psychiatrist in Ireland'.

"One of the main benefits to working with a peer support worker is that of positivity; seeing someone who has experienced mental health problems but has moved forward and is now working. I believe the PSW is good at validating service users' experiences whilst also seeing the potential in people and being able to identify people's strengths rather than looking at all the negatives."

Mental health professional

"I would like to think that my practice very much embraces the concept of recovery, yet (the peer support worker) has arrived and made me pause and rethink, not in a critical way but in a gentle questioning way."

Consultant psychiatrist

(Repper et al, 2013).

2.6. Peer Support- Experiences of a Peer Support Worker and Consultant Psychiatrist

In striving to deliver Recovery focused services there is a need to provide evidence that recovery is possible. The development of the peer support role is perhaps one of the most hope inspiring examples of Recovery for those using mental health services.

In setting up a new service for those in need of an intensive inpatient rehabilitation, a peer support worker was employed as a member of the MDT. The peer support worker works 9-5 Monday to Friday. They provide 1;1 support and group education to the service users in addition they attend MDTs, clinical reviews, and family meetings. Groups covered include, “Shared experience” allowing service users relate their symptoms to others in addition to educational groups, Recovery, Anxiety Stigma, Discrimination, Physical and Mental Health, Personal Experience Recovery, Motivational Tips. Individual sessions are provided to service users to support community integration, vocational activity, and life skills. Peer support emphasizes the core belief that each person’s experience of recovery is unique and the 1;1 approach is focused on identifying what works for individual service users.

From the service user perspective, the presence of a peer employed as part of the mental health team is initially met with surprise. Invariably, as time moves on, the peer support role is identified as a positive way to use the experience of an inpatient stay. A number of service users have expressed an interest in working in this area. The presence of peer support in family meetings has proved reassuring to families when they are struggling to find “hope” that their family member can make a full recovery. Families have asked the peer, “So can they get as well as you, really get better?”.

The impact on colleagues working in teams alongside peer support workers has been significant, prompting the team to reflect on our ways of working. Mental Health Professionals sometimes have “to hold the hope” of recovery and motivate service users that it is achievable. Sometimes that can be a struggle. Our team have all been inspired by their peer support colleagues” lived experience”. On occasion it has proved a timely reminder that recovery is possible even in difficult circumstances. The Peer support worker has talked about their experience assisting the team to have a greater understanding and empathy for the service users they work with.

The peer support worker has been invaluable in providing guidance and education to the team. They have particularly contributed to MDTs and care planning in focusing the team to use Recovery focused language in our interactions with service uses. They have supported the team to consider emotions service uses may experience following episodes of distress. Service users can feel embarrassed and the anxious engaging with team members post distressing incidents. This has been of relevance when conducting incident reviews.

The experience was not without its challenges for the psychiatrist. The role of peer support was new to the organisation. The peer support worker was joining a new service and a newly formed MDT

The psychiatrist working on the team advocated for the role and made the business case that peer support was a core team member. Prompting the organisation to source external expertise (A Peer) in interviewing and recruiting for the role was essential. It was necessary to ensuring that the peer support worker had access to educational opportunities to progress their role. The psychiatrist took a laed in integrating and supporting the peer support worker on joining the organisation. It was essential that the Peer Support worker was not seen as role “to tick a box” . Educational sessions on recovery, external speakers and engagement with services employing peer support workers all formed part of the business case and pre employment preparation.

Recovery Colleges and Co-Production

Recovery colleges or recovery education centres have been established across a number of mental health services in Ireland where an adult education approach is adopted to support patients individual recovery and social integration through collaboration between mental health professionals and service users and their family carers. This co-production relationship has been demonstrated to be highly effective in a number of countries (ref.). As in other areas of health care provision where policy mandates a change towards the co-production of care in collaboration with patients and service users (Bovard, 2007), a similar transformation is mandated for mental health care. The principles involved are similar to those underpinning a number of practice areas already considered including shared decision making and self-management support above. (see box 2.7. 'Recovery in Practice: Recovery education programmes in the National Forensic Mental Health Service' and box 2.8. EOLAS as an example of Co-production ')

2.7 Recovery in Practice: Recovery education programmes in the National Forensic Mental Health Service

Although integrating recovery principles into care pathways in forensic settings can present challenges, the rolling out of several recovery initiatives at the National Forensic Mental Health Service (NFMHS) show that this can be achieved:

EVOLVE Recovery College opened its doors in the Central Mental Hsopital in November 2018. As for all Recovery Colleges, EVOLVE equally values the expertise gained from lived experience with that gained through professional training. The Recovery College complements traditional treatment approaches by providing educational programmes to help people realise and grow their personal strengths and resourcefulness in order to become experts in their own self-care, make informed choices and to pursue goals they feel are important.

Courses are co-produced and co-delivered by experts with lived experience, carers of people with mental ill health, peer trainers and health professionals. Recovery colleges provide opportunities for us all to participate in sharing our 'lived' and 'learned' experiences and to enjoy working together - not as carers, patients or service providers, but simply as students.

The vision of the recovery college to support and connect service users, service providers and family and friends by facilitating world class recovery education programmes. All students will have this opportunity. Success is when we nurture hope, personal-choice and empowerment in our students.

The mission of the Recovery College is to inspire students in the pursuit of their personal goals on their journey to recovery. This will be done in a safe space. We will be recovery-focused through inclusive consultation, self-determination and co-production. We will achieve this through peer education in an enjoyable, non-judgemental and trusting manner. Moreover, this will be done in a sincere, equal and compassionate way.

There are two Peer Educators working in the College who support the co-production and co-faciliation of the various educational modules. Many service users have already suggested, developed, or co-facilitated workshops. Ideas for courses come from everyone connected to the hospital- service users, staff, family/carers, and the Peer Educators themselves.

Examples of courses we have run to date include:

- 'Introduction to Recovery,'
- 'Exploring Schizophrenia,'
- 'Be Well, Stay Well,'

Practical steps for the psychiatrist to support co-production are (Boyle et al, 2010):

- *Recognising people as assets* - transforming the perceptions of people as passive recipients of care and 'burdens' on the system, to equal partners in designing and delivering services.
- *Building on people's existing capabilities* - actively supporting people to recognise and use their strengths, rather than conforming to a deficit model.
- *Reciprocity and mutuality:* - offering people who use services opportunities to develop reciprocal relationships with professionals (and with each other) and enter into mutual responsibilities and expectations.
- Peer support networks - enhancing knowledge generation and transfer through engaging personal and peer networks alongside those of professionals. Breaking down barriers - blurring the distinctions between professionals and producers and consumers of services. Reconfiguring the power relations and the way services are developed and provided.
- Facilitating rather than delivering - enabling professional staff to become catalysts of change, instead of sole providers of services.

2.8. EOLAS as an example of Co-production

Given the intangible nature of many of the principles of Recovery-focused practice, which relate to attitudes and culture as much as structures and procedures, it can be difficult for psychiatrists to gain practical 'real-world' experience of a Recovery-focused programme. The EOLAS Programmes for psychosis provide such experience. The EOLAS Programmes are parallel programmes that provide information and support for people who have experienced psychosis and for their families/supporters. The Programmes were developed to promote Recovery principles, and at the same time, aim to provide evidence-based, reliable information to enhance understanding of psychosis and of different approaches to treatment. EOLAS thereby functions as a bridge between the perspective of clinical practice (i.e. providing information on diagnosis, treatment and clinical recovery) and that of Recovery principles (e.g. empowerment, hope and self-responsibility in identifying personal goals for recovery and in taking steps towards achieving these goals).

The EOLAS Project (which developed and oversees the delivery of the EOLAS Programmes) operates within the Recovery Framework of the HSE, and is an alliance of service users, family members, clinicians, voluntary sector agencies and the HSE. The EOLAS programmes have been co-produced i.e. the content was designed based on a wide consultation with service users, family members and clinicians. The Programmes are co-facilitated by a peer and clinician facilitator, working in collaboration and with a balance between the contribution of lived experience and clinical expertise. The Programmes have been formally evaluated by a research team based in the School of Nursing and Midwifery at T.C.D. which includes service user/peer representation, and have been found to be highly effective in providing information and in promoting Recovery. EOLAS has been adopted by Mental Health Division of the HSE as part of the suite of services and supports to be offered to people with experience of psychosis and their families around the country.

Given this background, involvement in the delivery of the EOLAS Programmes in local services around the country provides psychiatrists with an ideal opportunity to gain practical experience of participating in and contributing to the delivery of a Recovery-focussed programme, which is of proven benefit to service users and families. Psychiatrists can contribute by:

- working with their MDT teams to identify and refer all service users and families/friends who might benefit form participation in the EOLAS Programmes,
- by participating as guest speakers in the relevant Modules of the EOLAS Programmes,
- by supporting the local EOLAS Coordinators to negotiate the necessary resources and support from the local management team and to ensure that the EOLAS Programmes are available to all those in the local catchment area who might benefit from them.

Supported Employment

Most people with severe mental health problems want to work though only 5 - 15% are actually in employment representing a huge waste of potential as well as denying people opportunities for social inclusion, meaningful daytime activity and a sense of personal identity and achievement. The *Individual Placement and Support (IP*S) approach is the most extensively evaluated form of assistance for accessing employment opportunities in people with mental illness and is currently being expanded across mental health services in Ireland. There is a considerable body of evidence to support the positive impact of IPS in sourcing, attaining and maintaining employment. A Cochrane review of 18 RCTs showed this methodology to be effective in supporting people to make the transition to paid employment (Crowther, et al, 2001).

Paid employment is associated with reduced admissions, reduced service use, reduced symptoms, improved quality of life, enhanced social networks (e.g. Bond, 2008).

There is now a substantial body of evidence from across the world that IPS is significantly more effective at helping people with schizophrenia to gain competitive employment than standard vocational services (Crowther et al 2010). IPS services have also been consistently shown to have very positive outcomes in terms of clinical measures. Meta-analysis has shown that IPS schemes significantly improve symptoms of thought disturbance, anergia and depression and improve total symptoms (Campbell et al 2011). IPS also leads to significant reductions in service use and associated costs resulting from improvements in mental health that competitive employment brings. See Box 2.9. IPS in the Irish Context.

2.9. IPS in the Irish Context Integrating Employment and mental health supports

Individual Placement and Support (IPS), also known as 'evidence-based supported employment', is a model that facilitates people with mental health difficulties to move into mainstream competitive employment. Under the IPS model, anyone is viewed as capable of undertaking competitive paid work in the community, if the right kind of job and work environment can be found and the right support is provided.

The Integrating Employment and Mental Health Support (IEMHS) project piloted the IPS model by integrating an EmployAbility Employment Specialist into each of four HSE Multidisciplinary Mental Health Teams (MDTs), in order to deliver an IPS service in four sites across Ireland.
The participating sites were in Castlebar, Galway, Cavan/Monaghan and Bantry. There were two distinct types of mental health teams involved in the IEMHS project: Rehabilitation and Recovery Teams (Castlebar, Galway and Cavan/Monaghan), and a generic Community Mental Health Team (CMHT, in Bantry). Rehabilitation and Recovery Teams provide specialized mental health care for people with severe and enduring mental health difficulties, whose needs cannot be adequately met by general adult services.

The IPS model involves eight key principles:
1. Competitive employment is the primary goal
2. Everyone who wants to work is eligible for employment support
3. Participants are helped to look for work which suits their preferences and strengths
4. Job search and contact with employers begins quickly - within four weeks
5. Employment specialists are based within clinical teams, and work with the team to support people to find paid employment
6. Support is ongoing and arranged to suit both the employee and employer
7. Benefits advice is given as part of the return to work
8. Strong relationships are built with employers

Integrating Employment and Mental Health Support (IEMHS) was developed with Genio and Department of Employment Affairs and Social Protection (DEASP) funding and in partnership with the Health Service Executive (HSE) Mental Health Division, the Department of Employment Affairs and Social Protection and EmployAbility companies. Mental Health Reform managed and evaluated the project.

The overall aim of the IEMHS project was:
To demonstrate how existing mental health and supported employment (EmployAbility) services can fulfil the best practice Individual Placement and Support (IPS) model of supported employment through improved integration with mental health services**.**

(Steps Into Work, Integrating Employment and mental health supports Final Report, 2017)

Other Practices

Two additional areas of recovery oriented practice included in published guidelines are 'health and wellness focused care' and 'trauma informed care' (APA, 2012). These were not addressed in detail in the College workshop activities and have not been detailed in this position paper. Readers are referred to Appendix 2 for further resources.

Organisational Context

Participants in the College workshops on recovery identified a number of other examples of good recovery oriented practice in current mental health services in Ireland along with a number of barriers- see Appendix 1. A prominent theme was the organisational culture within which evidence based recovery oriented practices are to be delivered and the reality that optimal outcomes cannot be achieved without the necessary conditions to support recovery oriented practice at the service level. This includes a range of organisational factors which need to be addressed in order to ensure integrated care and collaborative practices within the mental health services. The National Framework for Recovery in Mental Health (Health Service Executive, 2018) is relevant in this respect. See box National Framework for Recovery Principles See Box 2.10. National Framework for Recovery Principles.

2.10 National Framework for Recovery Principles

Principle 1: The centrality of the service user lived experience

- Service users are supported to have the understanding and knowledge to define their own recovery with access to the opportunity and resources to pursue that recovery.
- Service users define their own recovery goals for their lives, utilising service supports as appropriate. The articulation of self-determination is a central component of care planning.

Principle 2: The co-production of recovery promoting services between all stakeholders

- Service users are supported to co-produce their own recovery objectives
- The service will have capacity building measures on co-production and opportunities for all stakeholders to participate in co-production
- The contribution of all stakeholders is recognised as having a value attached and the stakeholder is rewarded appropriately
- The service has or will develop a strategic approach to co-production, shared decision making and recovery promoting relationships

Principle 3: An organisation commitment to the development of recovery-oriented mental health services

- The service has a co-produced mission, vision and values statement that promotes recovery contained in its service plan
- All mental health staff are supported to adopt the mission, vision and values of recovery in all their interactions with service users, families, carers and other stakeholders
- The experience of the service user, family members and carers in engaging with mental health services is used to support the design and delivery of services
- The service has a strategic approach to engaging people with lived experience as part of the workforce.
- The service supports a full range of participation of service users, family members and carers, tailoring supports for populations or individuals who may need support to advocate for themselves
- The service will co-produce a strategy to communicate the recovery approach of the service to meet diverse communication needs of its stakeholder groups
- The service will adopt an organisational approach to co-produced evaluation strategies to monitor effectiveness of its recovery approach and will include appropriate validated outcome and process measures from all stakeholder perspectives

Principle 4: Supporting recovery oriented learning and recovery oriented practice across all stakeholder groups.

- The service develops a co-produced recovery education plan to build the recovery capital and literacy of all stakeholders
- The service has a human resources strategy that supports recovery at every level of the organisation by ensuring that appropriate supports and resources on recovery are available to staff
- The organisation as a whole will develop a set of universal recovery competencies for all mental health staff.

(A National Framework for Recovery in Mental Health, Health Service Executive, 2018)

The participants in the College recovery workshops also identified another fundamental concern, namely the availability of resources both in terms of treatment options and time and how this may impact on the development of individual practitioners' recovery oriented practice. However, it was acknowledged by the majority of the College members who took part in the work of developing this paper that although resourcing is an important consideration in day to day practice this is not a determining factor when it comes to supporting recovery. Developing a greater recovery orientation does not actually involve an additional burden in practice. Rather recovery oriented practice is about "*… getting the basics right. It is about refocusing the conceptual compass guiding all practice and service development as as to be fundamentally oriented on enabling outcomes valued by the people we seek to serve.*" (Roberts & Boardman, 2013, p 43). See BOX 2.11. Practical steps for the psychiatrist to develop recovery oriented practice (Shepherd, 2008):

2.11. After each interaction with someone, reflect on whether or not you were supporting their recovery and ask yourself:

Did I:

- actively listen to help the person to make sense of their mental health problems?
- help the person identify and prioritise their personal goals for recovery (not professional goals)?
- demonstrate a belief in the person's existing strengths and resources in relation to the pursuit of these goals?
- identify examples from my own lived experience, or that of other service users, which inspires and validates their hopes?
- pay particular attention to the importance of goals which take the person out of the 'sick role' and enable them actively to contribute to the lives of others?
- identify non mental health resources- friends, contacts, organisations- relevant to the achievement of their goals?
- encourage the person's self-management of their mental health problems?
- discuss what the person wants in terms of therapeutic interventions, for example psychological treatments, alternative therapies, joint crisis planning, respecting their wishes wherever possible?
- behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together, indicating a willingness to 'go the extra mile'?
- while accepting that the future is uncertain and setbacks will happen, continue to express support for the possibility of achieving these self- defined goals- maintaining hope and positive expectations?

Frequently Asked Questions about Recovery Oriented Practice

(Adapted from Davidson et al., 2006 and Shepherd et al., 2008)

Question:	**'What's all the hype? We've being doing this for decades' ('*Recovery is old news')***
Answer:	Personal recovery is the core business of psychiatric services and as such requires organisational commitment to transform the culture, promote hope and support self-directed living in partnership with patients.
Question:	**'What's the evidence-base/ effectiveness case for recovery oriented practice? ('*Recovery-oriented services are neither effective nor evidence based')*.**
Answer:	There is extensive evidence of effectiveness and cost efficiency for a range of recovery promoting interventions- peer support, advance directives, wellness recovery action planning, illness management, strengths model, recovery colleges, supported employment and supported housing. Furthermore, in addition to the cost effectiveness of recovery oriented services patients own testimonies have validity and there are also significant personal and health gains with a recovery approach mediated through social inclusion.
Question:	**'You mean I not only have to care for and treat people, but now I have to do recovery too?' ('*Recovery-oriented care adds to the burden of mental health professionals who already are stretched thin by demands that exceed their resources')*.**
Answer:	A recovery orientation requires reconsideration of how to apply the important clinical skills of assessment and treatment rather than replacing them. Effective recovery working has the potential to reduce workloads by replacing less effective practices and interventions.
Question:	**'What do you mean your patients are in recovery? Don't you see how disabled they still are? Isn't that a contradiction? ('*Recovery means the person is cured')*.**
Answer:	Cure and recovery are not the same. While the patient may continue to require professional treatment, their recovery is about how they can and wish to live their life by accessing their own resources and other supports. Treatment may be one element of recovery.
Question:	**'You're not talking about the people I see. They're too disabled. Recovery is not possible for them'. ('*Recovery happens for very few people with serious mental illness'*).**
Answer:	Personal recovery is possible for people with severe mental illness. However, individuals may vary in terms of their understanding or their readiness in taking responsibility for their recovery. It is the professional's role to ensure that the process is encouraged and supported.

Question:	**'Isn't this is just the latest flavour of the month and one that sets people up for failure'. (*'Recovery in mental health is an irresponsible fad.')***
Answer:	Recovery is the future of mental health services and is consistent with practice developments in medicine generally, such as empowerment, self-management and the principles inherent in disability rights, social inclusion.
Question:	**How can I talk to them about recovery when they have no insight about being ill? (*'Recovery only happens after, and as a result of, active treatment and the cultivation of insight.' 'My patients won't event acknowledge that they're sick'.)***
Answer:	Agreeing a shared understanding of the nature of mental distress is desirable but not a pre-requisite for recovery. The professional's role is to support the patient in finding meaning that allows her/ him to realise hopes and goals for living. Treatment can contribute to this but it is the patients actions which will achieve it.
Question:	**'Sure, we'll be happy to do recovery; do you have the money it will take to start a new recovery programme?' (*'Recovery can be implemented only through the introduction of new services').***
Answer:	Recovery focused practice is about applying professional skills and existing resources to the task of supporting patients to get on with their lives. This requires listening anew to what patients value in their lives and new thinking about how we do our work not simply getting new resources.
Question:	**Why did I just spend ten years in training if someone else, with no training is going to make all the decisions? ('*Recovery approaches devalue the role of professional intervention.')'***
Answer:	Recovery oriented care is not about no longer being professional or not exercising hard gained expertise. Supporting recovery is about why and how we apply our knowledge, skills and competencies.
Question:	**If recovery is the person's responsibility, then how come I get the blame when things go wrong? (*'Recovery increases providers exposure to risk and liability.')***
Answer:	It is not the case that professionals carry sole responsibility for how patients live their lives. Other than in exceptional circumstances risk is shared between professionals, patients and others but the individual is responsible for that risk if for example a choice is made to disregard clearly documented professional advice (in the case of a patient) or a professional disregards a safeguarding duty. Practicing in a recovery oriented way means evaluating and managing risks in collaboration with others and in a responsible way in order to support opportunities for learning, growth and change.

(Adapted from Davidson et al., 2006 and Shepherd et al., 2008)

RECOMMENDATIONS

The following actions are recommended to support the development of recovery oriented psychiatric practice:

Values and Principle:

1. Psychiatrists to inform themselves of the origins of, and principles underpinning recovery oriented practice.

2. Recovery oriented psychiatric practice development to be led by the guiding values of all healing professions, in particular hopefulness, compassion, empathy, kindness, diversity, choice, meaningfulness, acceptance, inclusion, citizenship, partnership working, mutual respect, and empowerment.

3. Psychiatric training and practice to be informed by recovery principles in keeping with good professional practice guidelines and the College's guidelines and regulations in relation to ethics and reflective practice.

Recovery Oriented Practice Development:

4. Recovery oriented psychiatric practice to be strengthened through personal reflection and reflective practice and participation in training activities including recovery principles training and co-produced teaching and learning and recovery college activity and the use of patient narratives.

5. Recovery oriented psychiatric practice development to be conducted in the context of integrated, coordinated and person centred care.

6. Recovery oriented psychiatric practice development to prioritise the acquisition of specific competencies including strengths based approaches, shared decision making, collaborative care, self-management support, personal recovery care planning, socially inclusive approaches, amongst others.

7. Recovery oriented psychiatric practice to take particular account of the expertise of others and of specific recovery promoting approaches including peer support work, supported employment and housing support, amongst others.

Service Development:

8. Recovery oriented psychiatric practice to be strengthened by means of participation in local and national quality improvement initiatives to support recovery.

9. It is recommended that psychiatrists continue to collaborate in interdisciplinary mental health teams to improve mental health services in accordance with the common values underlying good psychiatric practice and recovery focused care.

10. It is recommended that the College continues to promote recovery oriented practice, to advocate for the necessary resources in services on behalf of the membership including efforts to address societal and whole mental health service change to promote the development of more recovery focused services.

Training and Continuous Professional Development:

11. It is recommended that psychiatrists and psychiatric trainees avail of training opportunities in their local services such as recovery principles training, shared decision making, recovery care planning, recovery focused approaches to risk and safety planning along with the necessary supports in terms of time, opportunities for reflective practice and peer educational group activities.

12. It is recommended that continuous professional development and undergraduate and postgraduate psychiatric education is informed by best evidence based practice in keeping with national guidance on recovery education- Recovery Education Guidance Document and co- production approaches- Co-production in Practice and Family Recovery Guidance Documents.

13. It is recommended that the College ensures the delivery of comprehensive educational and practice development materials and supports to address gaps in recovery relevant knowledge and skills at all levels of basic and higher training and by means of continuous professional development in addition to recovery content relevant to the undergraduate medical curriculum in medical schools.

14. It is recommended that all educational and practice development activities should, wherever appropriate incorporate the voice of the service user and carers through for example, the inclusion of the College REFOCUS committee (Recovery Experience Forum of Carers and Users of Services) members and contributions.

15. It is recommended that the College supports the development of further guidance on recovery focused practice relevant to each area of psychiatry subspecialty practice including child and adolescent psychiatry, psychiatry of later life, forensic psychiatry, addictions and intellectual disability.

Research:

16. It is recommended that the College engages with appropriate academic partners in the development of guidance for personal recovery research methodologies.

17. It is recommended that all research and service evaluation activity should, wherever possible incorporate the contribution of service users and carers.

Conclusion

The experience of College members who participated in the recovery workshops in 2018 was that people with mental disorders can enter a process of personal recovery despite ongoing symptoms and difficulties and that recovery oriented practice is relevant to those who do not achieve full clinical recovery but who can learn to manage the disorder and live a satisfying life.

Recovery is comprised of different components, including clinical, social and personal elements but from the perspective of the individual with mental illness it means gaining and retaining hope, understanding of one's abilities and disabilities and engagement in an active purposeful life. Recovery focused practice is firmly based in the evidence for effectiveness of a range of interventions while a more collaborative approach to mental health care provision has been shown to lead to positive outcomes for service users and family members such as improved quality of life, higher levels of satisfaction with services, increases in users' participation in treatment and improved health outcomes. From the perspective of the psychiatrist Recovery oriented practice differs from traditional approaches by emphasising hopefulness over therapeutic pessimism, collaboration over autocratic practices, empowerment over paternalism and coaching over directive approaches. Although the ideas of person centred care, collaborative working and promoting autonomy are not new, the practical challenges to their implementation in every day practice need to be addressed.

In the same way that psychiatrists cannot 'recover' people directly, recovery outcomes at the individual patient level cannot be achieved without the necessary conditions to support recovery oriented practice and access to appropriate supports at the service level. This involves a range of organisational, social and cultural factors which need to be addressed in order to ensure integrated care and collaborative practices both within and between mental health and other support services.

The psychiatrist's clinical role has changed dramatically over time in parallel with the deinstitutionalisation process and other mental health service reforms. As psychiatry continues to evolve recovery represents a conceptual framework that allows more balance between the biomedical and humanistic elements of care - a genuinely bio-psycho-social approach in practice. The recovery approach also provides psychiatrists with the opportunity to exercise their clinical and leadership responsibilities in ways that highlight the distinct identify of the profession within medicine. After all, recovery oriented practice is consistent with the fundamental values of psychiatry and represents a natural evolution of psychiatry as a core medical discipline by promoting greater patient participation in society through attention to the rights of people with mental disorders and advocacy in respect of equality in treatment, social exclusion and stigmatisation.

Recovery oriented practice not only offers psychiatrists the opportunity to improve outcomes for patients and the quality of mental health services, it also represents practice that is clearly ethical (this is what people using services and their families want) more effective (in terms of achieving personal goals) and more eefficient (supporting people

to live the lives they want reduces the need for services). Adopting a recovery approach also provides greater professional fulfilment through the exercise of those values which initially attracted individuals to the profession and by working with patients in empowering therapeutic relationships. Whereas the psychiatrist's specialist medical skills in assessment, diagnosis and treatment remain necessary and important, modern psychiatric practice requires a change from a confining biomedical approach to ways of working alongside people who use services and their carers to support patients to get on with living. Two central consideration arising from the recovery approach are how can psychiatric practice move beyond a focus on clinical priorities to fully support patients recovering the life they choose (a clarification of the purpose of our work) and how to develop the relevant ways of working with the patients we support (a new type of relationship).

Recovery oriented practice comes with a number of challenges and opportunities for change. In view of the significant clinical and leadership roles played by psychiatrists it is apparent that greater consideration needs to be given to how we incorporate evidence based recovery oriented practices to support patients' recovery goals. In addition there are implications for the health systems in which we work. For example, in how psychiatrists exercise leadership in the process of changing the operation of mental health services especially when faced with limited resources and in our efforts to achieve parity of esteem and funding for mental health services. A number of areas will require review and further consideration in terms of the training, supervision and continuous professional development needs of practitioners and in relation to psychiatric research where the role of mental health professionals and mental health services is to create the right kind of supportive environments along with the appropriate interventions to help people achieve their own goals. The contents of this paper and the interventions outlined can act as a guide to address some of the training and continuous professional development supports needed for the development of recovery knowledge, skills and competencies relevant to recovery oriented practice.

The College recommends this paper to the membership and commits to support the development of recovery focused training, education and professional practice and to the leadership for mental health service improvement into the future.

"Psychiatrists need to appreciate the strengths and values of different stakeholders, articulate their views in a language free from medical jargon, and lobby, negotiate, and compromise with stakeholders with contrasting views to devise optimal care plans for their patients"

(The WPA- Lancet Psychiatry Commission on the Future of Psychiatry, Bhugra et al. 2017, page 786).

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Whitmore, J (2002) Coaching for Performance. Nicholas Brealey.

World Health Organisation (2013) Mental Health Action Plan 2013-2020. Geneva: WHO

Zipursky RB, Reilly TJ, Murray RM. (2013). The myth of schizophrenia as a progressive brain disease. Schizophr Bull. 39(6):1363–1372. doi:10.1093/schbul/sbs135

APPENDIX

APPENDIX 1

What is Recovery? College of Psychiatrists of Ireland Workshop Exercises

A series of workshops on recovery were hosted to which members of the college were invited in order to contribute their current experiences and to clarify the priority areas for consideration and future development. The views of a large number of members were captured during the course of interactive workshop events which involved short plenary presentations and facilitated small group discussions guided by experienced moderators with a background in recovery focused service developments and a combination of professional and personal experience of mental illness. Approximately ninety-five College members took part from across the spectrum of psychiatric subspecialty areas (General Adult, Child and Adolescent, Intellectual Disability, Rehabilitation, Forensic, Clinical Management and Academic Psychiatry) and from both the public and independent sectors in Ireland. A small minority of participants were psychiatric trainees. The emergent themes were collated and were used in addition to information provided by participants by means of semi-structured feedback.

Principles which Support Recovery (Shepherd et al, 2008)

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing symptoms or problems.
- Recovery represents a movement away from focusing solely on pathology, illness and symptoms to health, strengths and wellness.
- Hope is central to recovery and can be enhanced by people discovering how they can have more active control over their lives and by seeing how others have found a way forward.
- People are encouraged to develop their skills in self care and self management in whatever way works for them. There is no 'one size fits all'.
- The helping relationship between clinicians and patients moves away from being 'expert versus patient' to mentoring, coaching or partnership on a journey of personal discovery. Clinicians are there to be 'on tap, not on top'.
- Recovery is about discovering and often re-discovering a sense of personal identity, separate from illness or disability.
- People do not often recover in isolation. Recovery is closely associated with being able to take on meaningful and satisfying social roles and participating in local communities on a basis of equality.
- Words are important. The language we use and the stories we tell have great significance to all involved. They can carry a sense of hope and possibility, or be associated with a sense of pessimism and low expectations, both of which can influence personal outcomes.
- The development of recovery based services emphasises the personal qualities of staff as much as their formal

What is Recovery?

The most commonly cited definition of personal recovery (Anthony, 1993; page X above) which was also presented at the workshop events was acknowledged by participants as helpful and meaningful. Whilst a number of participants spoke of a lack of information about, and limited understanding of recovery, the majority identified working with a

recovery focus as 'just good practice' though not without its challenges. Participants, when asked to reflect and share on those aspects of their practice which were more recovery focused identified a range of attitudinal and behavioural factors which were highly consistent with published guidance in this area. For example, the importance of hope. Many authors has stressed the central role of hope in personal (e.g. Lieberman & Kopelwicz, 2005; Snyder et al, 2006) while the absence of appropriate evidence based psychosocial treatment has been shown to undermine personal recovery by limiting support for hope and supported self-management (Harrow et al, 2005). See Box: Recovery Values and Working with Principles which Support Recovery

Recovery Values and Working with Principles which Support Recovery

Recovery Values

Working to Values which support recovery:

Hope	Diversity	Choice	Meaningfulness
Acceptance	Inclusion	Citizenship	Partnership working
Mutual respect	Empowerment	Person-centred	Believing in people

(Taken from 'Putting Recovery at the Heart of All We Do: What does this mean in practice?'Devon & Torbay NHS Trust, 2008 as adapted from 'Recovery- Concepts and Application' by Laurie Davidson, the Devon Recovery Group, 2008

Despite the potential for confusion or a lack of precision when considering aspects of clinical and personal recovery, most participants acknowledged the usefulness of 'consumer defined' recovery which has been increasingly influential on mental health policy and practice developments in numerous countries as much through political influence as through evidence of effectiveness or empirical validation (Bellack & Drapalski, 2012). However, personal recovery was accepted as a realistic possibility for people diagnosed with a mental illness in this country in keeping with empirical research and practice guidelines within the Irish context (for example guidance documents from the Mental Health Commission), evidence of the experience of recovery within cohorts of people in Ireland (for example Kartalova, and O' Doherty 2009), in mental health teams (McFarland, et al., 2009), through indicators of what a Recovery service could look like (Higgins 2008) and attempts to develop recovery orientated service improvement change models (Mac Gabhann et al. 2010). There was a consensus that recovery is not a linear process but a personal journey that involves a change in attitudes, beliefs and skills in order to live a hopeful and meaningful life. This was consistent with conceptual frameworks proposed for understanding and operationalising recovery are the presence of the triad of 'hope', 'control' and 'opportunity' identified for the service user (Repper & Perkins, 2003), and the concept of 'reconnecting with life' (Kartalova-O'Doherty and D Tedstone Doherty, 2010). An alternative conceptual framework based on a systematic review and narrative synthesis of the literature and international guidelines comprises five recovery processes: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (Leamy et al, 2011). A comprehensive framework to guide recovery oriented practice has also been proposed by LeBoutillier et (2011) based on a systematic review of professionals views of recovery. See Box: Best practice in supporting recovery. This identifies four domains which can guide how recovery support can be

operationalised in practice, two of which identify individual practitioner behaviours including '*working relationships*' and '*supporting personally defined recovery*' and two mental health system factors- '*organisational commitment*' and '*promoting citizenship*'. This framework underscores the central importance of the therapeutic relationship in supporting recovery by promoting hope and working in partnership (***working relationship*s**). The psychiatrist "…demonstrates a genuine desire to support individuals and their families to fulfil their potential and to shape their own future". '***Supporting personally defined recovery***' entails that the psychiatrist supports the patient in defining their own goals and plans for care and incorporates these as the central focus for treatment based on shared decision making and achieved through supported self management.

Whereas an identified need for good evidence to support the recovery approach emerged from the workshops, it was noteworthy that for the majority of workshop participants the question of evidence for the recovery approach appeared to be less of a priority than the values based rationale and the practical consideration for working in a recovery focused way (see Box: Recovery Values and Working with Principles which support recovery). This may have reflected the design and content of the workshop events which included comprehensive information on specific recovery promoting interventions and an expert's presentation of the research evidence and economic basis for a broad range of recovery promoting interventions and models of care (ImROC Business).

What is Working Well in Psychiatric Practice?

Workshop participants discussed the range of factors relevant to recovery in their day to day work and identified examples of good practices and recovery affirming experiences. Foremost amongst these were '*Being able to empower clients' and 'Being able to make a difference'*- the sense of fulfilment in working collaboratively with patients and carers, the value of attentive listening and being committed to the patient in terms of supporting their aspirations and goals in treatment. Furthermore, *'Seeing people do well'*, that is when patients actually achieved success in reaching life goals and could associate this with the clinical intervention, was particularly rewarding for the psychiatrist also as it provided a compelling sense of what recovery is; hearing patients positive experiences had a similar effect. Other participants highlighted the benefits to their practice and their sense of professional efficacy when they could instill hope and realistic optimism for recovery by building a connection with patients and maintain awareness of 'light at the end of the tunnel'. This was also the experience when a shared narrative was generated with the patient which helped to make sense of mental distress; for example asking the question 'What happened to you?' rather than 'What's wrong with you?' was more effective in this regard. A number of participants spoke of the importance of compassion and how a compassionate approach to care encompasses how psychiatrists can support patients' recovery. For example, compassion has been defined in the following way '*empathy, respect, a recognition of the uniqueness of another individual, and the willingness to enter into a relationship in which not only the knowledge but the intuitions, strengths, and the emotions of both the patient and the physician can be fully engaged*" (Lowenstein, 2008).

Participants also spoke about being comfortable in the helping role when faced with emotional distress by supporting the patient in becoming more aware of the wider context of their life; this approach was more supportive of recovery as it enabled a better understanding of the illness and helped to clarify priorities for treatment and care planning, for

example by identifying or rediscovering helpful social roles and supports. Another dominant theme which emerged was the common values base between good psychiatric practice and recovery ideas, such as supporting human rights or advocating for a vulnerable person. There was strong endorsement by workshop participants of the importance of observing and practicing in accordance with patients' rights. The principle of respect for patients and family members also arose in a number of contexts including having mutually respectful relationships with patients and in terms of how services communicate and in the quality of the physical environment provided and how this was demonstrable of respect or lack thereof.

Many participants also acknowledged the benefits of working as part of a group or in a multidisciplinary team environment for the effective delivery of good recovery focused care and others spoke of the need to maintain professional boundaries while at the same time being flexible and accessible to professional colleagues and patients. Adopting a 'personal approach' or an 'open door approach' was highlighted by other participants while communicating effectively was stressed by most participants. Unsurprisingly, there was a high level of awareness of recovery focused practices amongst the participants which, as previously stated were regarded by many as simply the natural way to work and which are in keeping with the consensus found in the mental health recovery literature- for example, the 'Sainsbury Centre's Top Ten Tips for Recovery Oriented Practice' (See Box: Practices which support recovery).

In terms of specific skills or competencies, workshop participants identified a number of aspects of their current approach to patient care which they regarded as more supportive of recovery including at the most fundamental level empathy, positive regard, being trustworthy and providing continuity of care. Adopting a structured approach in terms of time management, setting goals and planning for consultations and meetings was also seen as relevant. Other skills included being able to elicit hopes and priorities for their lives in even highly distressed patients and to incorporate these into treatment. Also important were being sensitive to the discrepancies in power and control experienced in doctor- patient transactions and recognising the limits of what the psychiatrist can do and the need to look beyond existing services for the resources that are needed to rebuild a life. As outlined above, such competencies were regarded as essential for effective recovery oriented practice. Many participants referred to a high level of professional satisfaction derived from an empowering approach to patient care and the benefit felt by themselves and by patients when the latter are encouraged to take control. The most effective and most recovery oriented practices were realised through 'safe, empowering and collaborative relationships'.

For other participants, recovery focused practice involved other specific considerations including the need to remain autonomous and the need to have positive professional experiences in order to maintain a hopeful, recovery oriented attitude. In this respect, it was evident that for many psychiatrists the capacity to practice in a recovery oriented manner was generated and sustained through a process involving patient feedback, self- reflection and good self-care. Examples provided included seeing the evidence for recovery in patients, making a tangible difference to patients' lives and being surprised by recovery such as when a patient achieved a level of functioning which was not anticipated. It appeared that some of the most encouraging experiences for psychiatrists were when the patient's objectives or non-clinical goals were realised at the same time as satisfactory professional task achievement such as

in formulation and diagnosis. This was often epitomised by the patient taking more control and responsibility for their care over the course of a good working relationship which was empowering for both. These views also resonated with findings from previous evaluations of recovery promoting competencies in mental health professionals, for example Borg and Kristiansen (2004) who specified openness, collaboration as equals, focusing on individual's inner resources, reciprocity and a willingness 'to go the extra mile' as key components for recovery practice.

Challenges and Barriers to Recovery

Notwithstanding the considerable number of positive aspects of their practices and some strengths in the services in which they worked the majority of workshop participants identified numerous obstacles to the delivery of more recovery focused mental health care. A number of themes emerged which appeared to have more consistent endorsement including:

- Legacy issues such as the historical lack of patient focus, non- recovery attitudes of some mental health staff and a tradition of large scale institutional care in Ireland.
- Lack of awareness of recovery ideas and lack of relevant knowledge and skills
- Resourcing issues including inadequate budgets, insufficient time for patient contact, excessive caseloads and fewer staff, excessive administrative work and lack of access to non- pharmacological therapies.
- Wider societal issues including stigma, lack of access to mainstream supports like housing, work opportunities and community resources for mental health patients and unrealistic expectations on the part of the community and some families.
- Organisational issues including staff demoralisation and burn-out, resistance to change and potential mis-use of recovery as a means to cut services.

- Professional concerns including fear of litigation, lack of training and apprehension that recovery may lead to the de-professionalisation of psychiatry

The '10 key organisational challenges'

1. **Changing the nature of day-to-day interactions**
2. **Offering comprehensive, coproduced learning opportunities for staff**
3. **Establishing a '*Recovery Education Centre*'**
4. **Ensuring organisational commitment at all levels**
5. **Increasing personalisation and choice**
6. **Changing the way we approach risk assessment and management**
7. **Replacing user-involvement with co-production**
8. **Transforming the workforce ('peer support workers')**
9. **Supporting staff wellbeing and resilience**
10. **Increasing opportunities for building '*a life beyond illness*'**

(ImROC, 2009)

The views expressed by workshop participants in relation to historical effects in Ireland confirmed the need for a whole service approach to implementing recovery oriented practices which has been identified both in national mental health policy and national service planning. A number of initiatives to develop mental health services which are more recovery oriented have been commenced (see page X) including Advancing Recovery In Ireland which currently operates in all HSE community healthcare areas in the country using a recovery implementation framework which was previously piloted in Irish mental health services to promote whole service change- Implementing Recovery: A Methodology for Organisational Change (see Box: The '10 key organisational challenges').

The views of the workshop participants were in keeping with findings of survey opinions expressed by the range of patient, family and staff members in previous publications this aspect of service development in Ireland. For example Watts et al., (2014) identified that factors preventing more recovery-oriented locally based services included the existence of a range of negative and hostile public, professional and cultural attitudes in… "*A mental health system that provides little choice of treatment, a risk averse culture and an extremely fragmented and limited range of services with poor levels of communication between practitioners and service users*". Furthermore, "*Service users also gave examples of unhelpful attitudes and behaviours among professionals, a failure to see the person behind the diagnosis, an over-reliance on medication and little encouragement to become involved in services outside mainstream mental health services*". However, some service users surveyed had positive recovery experiences of psychiatry, such as: "*If I can see the person in my consultant, and he can see the person in me, it changes the relationship completely. To tap into the inside of people, the human being behind the label, two hearts talking. Recovery happens in relationships. I get belief in myself through others. It's in cultivating human relationships*

between provider, family and service user that recovery happens". Another service user reported *"I have a good relationship with my psychiatrist she really listens to me and doesn't panic when I do.".* Mental health staff surveyed identified similar barriers to those highlighted by workshop participants in relation to the development of more recovery-oriented services (see Box: Building Capacity in Mental Health Services to Support Recovery).

Building Capacity in Mental Health Services to Support Recovery

Attitudes Regarding Mental Health Staff Developing Services to Support Recovery:

- *'Because we are so poor it's very hard to do anything except stop-gapping [crisis management] quite often you lose sight of recovery stuff'*
- *'I don't think [mental health services] are hopeful for service providers, I feel morale is terrible. Staff numbers have halved in the last few years…, ancillary services like community welfare have all been cut'*
- *'Understanding what personal recovery is and how services can be recovery oriented is difficult, most professionals are not anti-recovery but don't understand [recovery]'*
- *'It can be hard [for service users] changing from a medical approach and the idea that the practitioner knows best'*
- *'I think we are still a little in medical model in the team. We are moving slightly away from 'professionals can cure you' and medication; we are seeing it more as an adjunct, providing different types of therapies and sometimes that can be difficult for some aspects of the team'.*

(Watts et al., 2014)

Although the development of recovery focused services and professional practice is not likely to be achieved predominantly through resourcing, it is not surprising that concerns about the funding and staffing of mental health services in Ireland are of concern for psychiatrists at this time.

Workshop participants identified the need for more information about recovery and guidance on how to develop this area of practice. A number of participants cited the need to critically appraise the meaning of personal recovery and to have more open discussion about the recovery approach. Some participants spoke of a need to have more debate about what recovery means for the psychiatrist and how this can be incorporated into services while a small number were sceptical of this approach and its relevance to patients with severe mental illness and psychiatry in general. This perspective raised a number of points which have emerged in the recovery literature and continue to be debated by some authors (see Frequently Asked Questions).

Finally, a consensus emerged that due to the subjective, individual nature of patients' recovery experiences more sophisticated methods of evaluation are needed rather than standard and limited 'key performance indicator' or 'tick

box' approaches which have limited value both for identifying what's important for the patient and in guiding the psychiatrist's practice.

How to Address The Challenges and Barriers to Recovery?

A number of identifiable solutions and facilitating steps were identified by workshop participants in order to progress the development of more recovery oriented practices. The areas for change which emerged were broadly similar to those areas identified as challenges and barriers outlined above. Training and professional development opportunities were most commonly cited as necessary to address a lack of recovery knowledge and to respond to service areas or individual professionals where recovery knowledge or attitudes were insufficiently developed.

It became apparent that conventional or didactic approaches to recovery learning would not be sufficient, though brief updates or 'state of the art' presentations would be helpful. Participants in the workshops stressed the value of patient stories and presentations based on lived experiences of mental illness and the use of services- a common theme in recovery initiatives and addressed in published guidance (see Box Recovery Education). It became apparent that although many workshop participants were aware of national service initiatives to support recovery, there was little knowledge of ongoing developments or training opportunities available in their local services, such as recovery principles training. Many participants reported that they faced particular difficulty in availing of sufficient time to attend training events, in particular reflective practice and peer training activities. A number of participants identified a potential role for the College in supporting appropriate training and learning events to support the development of recovery focused practices.

While the issue of resourcing of mental health services was frequently cited in the context of overall service improvement the specific areas of most concern to workshop participants were the availability of time to allow for better quality patient interactions and for reflective practice, access to non- pharmacological therapies and allied health professions and team completion. Many participants recommended alternative supports to in patient care and hospitalisation as an important means of improving the overall quality of patient experience. There was also the recognition that psychiatry and mental health service providers alone can not achieve better recovery outcomes for patients and that this was a shared responsibility in need of a new collaborative approach in keeping with contemporary approaches to complex social needs which are best addressed through the application of 'co-production' principles (See Box Co-production). Participants stressed the need for shared responsibility across the wider community, in particular in terms of access to mainstream supports like housing, work opportunities and community resources for mental health patients as well as measures to effectively tackle discriminative attitudes both within and outside the health service. In terms of staff resources, the contribution of peer workers (individuals with experience of mental illness and recovery) was seen as particularly important to providing more patients with positive recovery experiences in services. Although only a small minority of workshop participants had knowledge of

this form of support it was endorsed as a powerful means of helping people to manage their mental health challenges.

The participants were appreciative of the College's role in arranging the recovery themed workshops and strongly endorsed the events which provided for individual reflective practice and sharing of experiences with colleagues in a secure learning environment. There was consistent endorsement also for the development of the recovery position paper which was identified as a significant support for the profession in clarifying and guiding the future development of recovery-oriented practice. Based on the feedback from the range of specialist practitioners, it was apparent that more focused deliberation on the application of recovery principles to each area of psychiatry subspecialty practice would be valuable, including child and adolescent psychiatry, psychiatry of later life, forensic psychiatry, addictions and intellectual disability.

Co-production

What is Co-production?

- **Creation of an Exploratory Space**

Where all stakeholders come together in order to create new knowledge

- **Collaborative Process**

All stakeholders share their various perspectives with a view to reaching desirable outcomes

- **Power Sharing**

A sharing of power between all stakeholders based on recognising different areas of expertise and resulting in shared ownership of decisions.

- **Enhancement of Knowledge**

Recognising, understanding and utilizing the various sources of knowledge

- **Relationship of Equals**

Relationships are based on mutual respect

- **Non- Linear**

A journey with ups and downs from which we learn

- **A Continuum of Practice**

Supporting recovery and service improvement at all stages of service provision.

(*Co-Production Guidance Document 2018-2020, Health Service Executive 2018*)

Participants clearly identified the importance of the College in leading and promoting recovery oriented practice in services on behalf of the membership. In particular, the College was seen to have a central role in advocating for societal and whole mental health service change to promote the development of more recovery focused services, communicating with members about recovery oriented initiatives and pilot projects and in facilitating the sharing of knowledge and good practice. Each workshop event identified the importance of education and training at all levels

to support recovery at basic and higher training levels and for full members by means of continuous professional development. It was noted also that education on recovery needs to start at undergraduate level in medical schools.

APPENDIX 2 USEFUL RESOURCES

1. COLLEGE OF PSYCHIATRIST OF IRELAND

Refocus Committee:

https://www.irishpsychiatry.ie/members/committees/refocus/

On the Road to Recovery:

https://bodywhys.ie/wp-content/uploads/2017/03/Ontheoneroadtorecovery-1.pdf

Recovery in practice The College of Psychiatrists of Ireland's Role- Dr John Hillery:

https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/resources/2016-11-college-of-psychiatrists-of-ireland-presentation.pdf

2. Guidelines for Recovery-Oriented Practice, Services

Recovery is for All: Hope, Agency and Opportunity in Psychiatry.

http://www.pillarkincardine.co.uk/pk4/pdf/Recovery.pdf

Advancing Recovery in Ireland

https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/resources/2016-11-how-recovery-offers-more-for-less-imroc-presentation.pdf

Building Capacity in Mental Health Services to Support Recovery.

https://nursing-midwifery.tcd.ie/assets/publications/pdf/ARI%20-report-final-report%2022-july-2015.pdf

Mental Health Commission, Ireland.

A Recovery Approach within Irish Mental Health Services. A framework for Development (2008).

https://www.mhcirl.ie/File/framedevarecov.pdf

A Vision for a Recovery Model in Irish Mental Health Services (2005).

https://www.mhcirl.ie/file/discpapvforarecmod.pdf

Department of Health, government of Australia:

https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc

Mental health commission of Canada:

https://www.mentalhealthcommission.ca/sites/default/files/2016-07/MHCC_Recovery_Guidelines_2016_ENG.PDF

Rethink, UK:

https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/100-ways-to-support-recovery/

Online resources:

http://www.scottishrecovery.net/resources/

Reflective practice for ROP:

https://scottishrecovery.net/wp-content/uploads/2008/07/Realising-Recovery-Module2.pdf

Team development to support recovery:

The Team Recovery Implementation Plan: A framework for creating recovery-focused services. London, England: Centre for Mental Health & Mental Health Network NHS Confederation, Implementing Recovery through Organisational Change (ImROC). Retrieved from https://www.centreformentalhealth.org.uk/team-recovery-implementation-plan

3. ROYAL COLLEGE OF PSYCHIATRISTS

Position statement Royal College of Psychiatrists. https://www.rcpsych.ac.uk/docs/default-source/mental-health/work-and-mental-health-library/position-statement-2009.pdf?sfvrsn=97bca29e_2

A Common Purpose: Recovery in future mental health services.

http://www.incontrol.org.uk/media/6318/a%20common%20purpose%20recovery%20in%20future%20mental%20health%20services%20.pdf

Mental health and social inclusion.

https://www.lenus.ie/bitstream/handle/10147/81317/Mentalhealth%26socinclu07.pdf?sequence=1&isAllowed=y

Recovery and Psychiatry subspecialties:

Recovery is for All: Hope, Agency and Opportunity in Psychiatry.

http://www.pillarkincardine.co.uk/pk4/pdf/Recovery.pdf

Scottish Recovery Network. (2014). Neither seen nor heard: What about recovery for children and young people? Retrieved from http://www.scottishrecovery.net/Latest-News/neither-seen-nor-heard-what-about-recovery-for-children-and-young-people.html

Spenser, H., Ritchie, B., Kondra, P., & Mills, B. (n.d.). Child & youth mental health toolkits. Hamilton, ON: Collaborative Mental Health Care. Retrieved from **http://www.shared-care.ca/toolkits**

Open dialogue-

www.rcpsych.ac.uk/workinpsychiatry/faculties/generaladultpsychiatry/aboutthefaculty/networks/opendialoguenetwork.aspx

4. WORLD HEALTH ORGANISATION

WHO Action Plan on Mental Health:

https://www.who.int/mental_health/action_plan_2013/en/

5. PSYCHIATRIC CURRICULUM

Person centred care curriculum Royal College of Psychiatrists (2018)
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr215.pdf?sfvrsn=7863b905_2

American Psychiatric Association:
http://www.psychiatry.org/psychiatrists/practice/professional-interests/recovery-oriented-care/recovery-oriented-care-in-psychiatry-curriculum

Canadian Psychiatric Association- Guidelines for training in cultural psychiatry:
http://www.academia.edu/2824551/Guidelines_for_Training_in_Cultural_Psychiatry

College of Psychiatrists fo Ireland:
https://www.irishpsychiatry.ie/wp-content/uploads/2016/12/Curriculum-for-Basic-Higher-Specialist-Training-in-Psychiatry-July-2012-Revision-5-July-2016-21.07.16.pdf

6.ENGAGEMENT AND WELCOMING ENVIRONMENTS

Selected publications

Davidson, L., Harding, C., & Spaniol, L. (2005). Recovery from severe mental illnesses: Research evidence and implications for practice (Vol. 1). Boston, MA: Boston University, Center for Psychiatric Rehabilitation. See excerpt at ***http://www.bu.edu/cpr/products/books/titles/sample-rsmi-1.pdf***

Schrank, B., Bird, V., Rudnick, A., & Slade, M. (2012). Determinants, self-management strategies and interventions for hope in people with mental disorders: Systematic search and narrative review. Social Science & Medicine, 74, 554–564. doi: 10.1016/j.socscimed.2011.11.008

Kruger, A. (2000). Schizophrenia: Recovery and hope. Psychiatric Rehabilitation Journal, 24(1), 29–37. doi: 10.1037/h0095126

Allott, P., Loganathan, L., & Fulford, K. W. (2002). Discovering hope for recovery. Canadian Journal of Community Mental Health, 21(2), 13–33.

Deegan, P. (1996, September). Recovery and the conspiracy of hope. Paper presented at "There's a Person In Here": The Sixth Annual Mental Health Services Conference of Australia and New Zealand, Brisbane, Australia. Re- trieved from ***https://www.patdeegan.com/pat-deegan/lectures/conspiracy-of-hope***

Allott, P., Loganathan, L., & Fulford, K. W. (2002). Discovering hope for recovery. Canadian Journal of Community Mental Health, 21(2), 13–33.

Resnick, S. G., Fontana, A., Lehman, A. F., & Rosenheck, R. A. (2005). An empirical conceptualization of the recov- ery orientation. Schizophrenia Research, 75(1), 119–128.

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). Others: The role of family, friends, and professionals in the recovery process. American Journal of Psychiatric Rehabilitation, 9(1), 17–37. doi: 10.1080/15487760500339410

Summerville, C. (2009). Hope in recovery: There is life after a diagnosis of mental illness. CrossCurrents: The Journal of Addictions and Mental Health, 12(4), 8.

7 PERSON CENTRED CARE- BIO-PSYCHOSOCIAL MODEL

Online resources:

Conner, A., & Macaskill, D. (n.d.). Providing person-centred support. Realising recovery, Module 4. Glasgow, Scotland: Scottish Recovery Network & NHS Education for Scotland: https://scottishrecovery.net/wp-content/uploads/2008/07/Realising-Recovery-Module4.pdf

Selected publications:

Roberts, G. (2000) Narrative and severe mental illness: what place do stories have in an evidence-based world? *Advances in Psychiatric Treatment,* **6**, 432-441.

Freeth R (2007). Humanising psychiatry and mental health care. The challenge fo the person centred approach. Radcliffe Publishing, Oxford

8 PATIENT NARRATIVES:

Glasby, J., & Beresford, P. (2006). Who knows best? Evidence-based practice and the service user contribution. Critical Social Policy, 26(1), 268–284.

Nelson, G., Lord, J., & Ochocka, J. (2001). Empowerment and mental health in community: Narratives of psychiatric consumer/ survivors. Journal of Community & Applied Social Psychology, 11, 125–142. doi: 10.1002/casp.619

9 SHARED DECISION MAKING

Shared decision making is a collaborative process through which a health care professional supports a patient to reach a decision about their treatment. There is increasing evidence in support of this approach overall and a growing evidence base from controlled trials specific to mental health care such as the use of shared decision making and joint crisis planning. Systematic review evidence has demonstrated that shared decision making leads to a greater sense of control and hopefulness (Shrank et al, 2012), better medication concordance (Drake and Deegan, 2012) and reduced need for seclusion (Health Foundation, UK, 2012). Henderson et al (2004) have demonstrated that joint crisis planning reduces compulsory admission and associated service utilisation costs while c

Making decision making a reality:
https://www.kingsfund.org.uk/sites/default/files/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf

Ahmad N, Ellins J, Krelle H, Lawrie M (2014) Person-Centred Care, From Ideas to Action: Bringing Together the Evidence on Shared Decision Making and Self-Management Support. Health Foundation:
https://www.health.org.uk/publications/person-centred-care-from-ideas-to-action

Selected publications on shared decision making in mental health:

Duncan, E., Best, C., & Hagen, S. (2010, January 20). Shared decision-making interventions for people with mental health conditions. Cochrane Database of Systematic Reviews. doi: 10.1002/14651858.CD007297.pub2

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K. & Szmukler, G. (2004) Effect of joint crisis plans on use of compulsory treatment in psychiatry: a single blind randomised controlled trial. *British Medical Journal,* **329**, 136-138.

10 SELF MANAGEMENT SUPPORT

Self-management support enables people with long-term conditions to manage their health and wellbeing, day by day, as effectively as possible. The following report brings together the evidence on self-management support and shared decision making by looking at four different, but interconnected, issues with an emphasis on practical applications.

https://www.health.org.uk/publications/person-centred-care-from-ideas-to-action

Self Managment Support- Resource:

http://personcentredcare.health.org.uk/resources?f[0]=field_area_of_care%3A273&f[1]=field_resource_type%3A345

Online resources:

https://scottishrecovery.net/wp-content/uploads/2008/07/Realising-Recovery-Module3.pdf

11 RECEOVERY CARE PLANNING

Wellness Recovery Action Planning

Online resources:

Copeland, M. E. (n.d.). The Wellness Toolbox. West Dummerston, VT: Mental Health Recovery. Retrieved from http://www. mentalhealthrecovery.com/wrap/sample_toolbox.php

Copeland, M. E. (n.d.). What is Wellness Recovery Action Plan® (WRAP®)? West Dummerston, VT: Mental Health Recovery. Retrieved from http://www.mentalhealthrecovery.com/wrap/

12 STRENGTHS BASED APPROACH

These include a strengths based approach which has been shown to reduce hospitalisation rates, enhance occupational functioning and increase hopefulness.

Selected publications:

Bird, V. J., Le Boutillier, C., Leamy, M., Larsen, J., Oades, L. G., Williams, J., & Slade, M. (2012). Assessing the strengths of mental health consumers: A systematic review. Psychological Assessment, 24(4), 1024–1033. doi: 10.1037/a0028983

Tse S, Tsoi, E., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., Whitley, R., Petrakis, M. Uses of Strength-Based Interventions for people with serious mental illness: A critical review. Int J Soc Psychiatry 2016;62:281-91

Online resources:

https://scottishrecovery.net/wp-content/uploads/2008/07/Realising-Recovery-Module6.pdf

13 WORKING WITH PEER SUPPORT

The employment of peer workers, that is individuals with experience of mental illness and recovery in Irish mental health services is one of the most visible signs of support for recovery implementation and is strongly supported by existing evidence including randomised controlled trials. For example Repper and Carter (2011) identified seven RCTs which demonstrated the positive impact of peer support workers across a range of clinical, subjective and social outcomes. Equivalent outcomes for peer support workers and professionals working in similar roles have been identified by a Cochrane review of 11 randomized trials, which utilised data from 2796 people in Australia, the UK and the USA (Pitt, et al., 2013). Compared with current services, the employment of Peer Support Workers was associated with equivalent effectiveness, no additional harm, and there was some evidence that their employment reduced the use of crisis services.

Practical steps for the psychiatrist in working with peer support (Repper, 2013):

Selected publications:

Repper J, Carter T. A review of the literature on peer support in mental health services. Journal of Mental Health 2011;20(4):392-411.

Sunderland, K., & Mishkin, W. (2013). Guidelines for the practice and training of peer support. Calgary, AB: Mental Health Commission of Canada. Retrieved from

Pitt V, Lowe D, Hill S, et al. Consumerproviders of care for adult clients of statutory mental health services. Cochrane Database of Systematic Reviews 2013(3) doi: Artn Cd004807 Doi 10.1002/14651858.Cd004807.Pub2

Online resources:

https://imroc.org/resources/5-peer-support-workers-theory-practice/

https://imroc.org/resources/7-peer-support-workers-practical-guide-implementation/

http://www.mentalhealthcommission.ca/English/system/files/private/document/Peer_Support_Guidelines.pdf

14 RECOVERY COLLEGES

Recovery colleges have been developed in a number of mental health service locations in Ireland as a means to drive organisational change in support of recovery using an adult learning approach and co-production between service users, family members and professionals. The empirical evidence available to date indicates that internationally, recovery colleges can promote greater self- management, increased hope and reduced use of community mental health services.

Resources:

https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/national-framework-for-recovery-in-mental-health/co-production-in-practice-guidance-document-2018-to-2020.pdf

https://imroc.org/resources/15-recovery-colleges-10-years/

Key publications:

Bovard, T (2007). Beyond engagement and participation: user and community coproduction of public services. Public administration review 67(5), 846-860

Rinaldi M, Suleman, M. Care coordinators attitudes to self-management and their experience of the use of the South West London Recovery College. London: South West London and St George's Mental Health NHS Trust 2012.

15 Risk and recovery

Mental health services can manage risk more effectively by involving service users in planning for safety. The following paper argues that risk and safety are rightly major concerns in mental health care but that traditional

methods of assessing risk have stood in the way of helping people to recover their lives. It argues that jointly produced 'safety plans' can be more effective ways of managing risk as well as enabling people to get on with their lives.

Boardman, J., & Roberts, G. (2014). Risk, safety and recovery. London, England: Centre for Mental Health & Mental Health Network NHS Confederation, Implementing Recovery through Organisational Change (ImROC): **https://imroc.org/resources/9-risk-safety-recovery**

Online resources:

https://imroc.org/resources/making-recovery-reality-forensic-settings/

Perkins, R., & Goddard, K. (n.d.). Sharing responsibility for risk and risk-taking. Realising recovery, Module 5. Glasgow, Scotland: Scottish Recovery Network & NHS Education for Scotland. Retrieved from https://scottishrecovery.net/wp-content/uploads/2008/07/Realising-Recovery-Module5.pdf

Publications:

Roychowdhury, A. (2011). Bridging the gap between risk and recovery: A human needs approach. The Psychia- trist, 35(2), 68–73. doi: 10.1192/pb.bp.110.030759

16 Supported Employment

Most people with severe mental health problems want to work though only 5- 15% are actually in employment representing a huge waste of potential as well as denying people opportunities for social inclusion, meaningful daytime activity and a sense of personal identity and achievement. The Individual Placement and Support (IPS) approach is the most extensively evaluated form of assistance for accessing employment opportunities in people with mental illness and is currently being expanded across mental health services in Ireland. There is a considerable body of evidence to support the positive impact of IPS in sourcing, attaining and maintaining employment.

Selected publications:

Heffernan, J. & Pilkington, P. (2011). Supported employment for persons with mental illness: Systematic review of the effectiveness of individual placement and support in the UK. Journal of Mental Health, 20(4), 368–380. doi: 10.3109/09638237.2011.556159

Online resources:

https://www.mentalhealthreform.ie/projects/integrating-employment-and-mental-health-support-iemhs/

World Association for Supported Employment. (n.d.). Handbook supported employment. Willemstad, Netherlands: World Association for Supported Employment / Geneva, Switzerland: International Labour Organization. Retrieved from http://www.wase.net/ handbookSE.pdf

17 Supported Housing

Sustained and suitable housing, an essential requirement for good mental health provides the basis for individuals to recover, receive support and return to work or training. Evidence from Ireland and abroad demonstrates that the 'housing first' approach is the most effective way to address the needs of people who are long-term homeless and is particularly suited to homeless people who have mental health and/or addiction issues. 'Housing first' emphasises securing tenancy for individuals and then providing them with a range of supports to help them maintain their tenancy. Housing support provides a three fold return on investment through savings on health, social and criminal justice service costs in the United Kingdom (NHS Confederation, UK, 2012) and in Canada with improved outcomes in terms of personal recovery goals and hopefulness (Kirst, et al, 2014).

Online resources:

https://www.genio.ie/our-work/homelessness

https://www.centreformentalhealth.org.uk/blog/centre-mental-health-blog/housing-first-helping-people-experiencing-poor-mental-health-find

https://www.housing.gov.ie/housing/homelessness/housing-first-national-implementation-plan-2018-2021

18 Organisational Development to Support Recovery

Advancing Recovery in Ireland:
https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/

National framework for recovery:
https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/national-framework-for-recovery-in-mental-health/

Recovery: A Journey for all Disciplines (2016) : ARI/HSE Mental Health Services. https://www.hse.ie/eng/services/list/4/mental-health-services/advancingrecoveryireland/resources/2016-01-recovery-a-journey-for-all-disciplines.pdf

Recovery: What you should expect from a good quality mental health service. (2013) Mental Health Reform. https://www.mentalhealthreform.ie/wp-content/uploads/2013/03/MHR-Recovery-paper-final-April-2013.pdf

Kidd, S. A., McKenzie, K. J., & Virdee, G. (2014). Mental health reform at a systems level: Widening the lens on recovery-oriented care. Canadian Journal of Psychiatry, 59(5), 243–249.

Shepherd, G., Boardman, J., & Slade, M. (2008). Making recovery a reality. London, England: Sainsbury Centre for Mental Health. Retrieved from **https://www.centreformentalhealth.org.uk/publications/making-recovery-reality**

Implementing Our 10 Key Challenges - ImROC https://imroc.org/about-us/implementing-10-key-challenges

https://imroc.org/resources/8-supporting-recovery-mental-health-services-quality-outcomes/

19 Recovery Research

https://imroc.org/resources/8-supporting-recovery-mental-health-services-quality-outcomes/

Farkas, M. (2007). The vision of recovery today: What it is and what it means for services. World Psychiatry, 6(2), 1–7.

Sklar, M., Groessl, E. J., O'Connell, M., Davidson, L., & Aarons, G. A. (2013). Instruments for measuring mental health recovery: A systematic review. Clinical Psychology Review, 33(8), 1082–1095. doi: 10.1016/j.cpr.2013.08.002

3 Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. British Journal of Psychiatry, 199, 445–452. doi: 10.1192/bjp.bp.110.083733

20 Books on recovery:

Selected publications:

Slade, M. (2009). Personal recovery and mental illness: A guide for mental health professionals. Cambridge, En- gland: Cambridge University Press.

Amering M, Schmolke M. Recovery in Mental Health. Reshaping scientific and clinical responsibilities (2009). Chichester. Wiley Blackwell.