A Vision for a Recovery Model in Irish Mental Health Services

"...fostering and promoting high standards in the delivery of mental health services..."
A Vision for a Recovery Model in Irish Mental Health Services

Discussion Paper

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Rationale and Background

In February 2004, the Mental Health Commission established a committee to consider the recovery model within mental health services. This committee was established in line with a number of the Mental Health Commission’s strategic priorities, in particular the following:

- to promote and implement best standards of care within the mental health services
- to promote and enhance knowledge and research on mental health services and interventions.

(Mental Health Commission Strategic Plan 2004-2005)

The Committee adopted the following terms of reference:

- to review different perspectives on and definitions of recovery
- to review models of best practice in recovery oriented services
- to define the process of recovery
- to consider how mental health services in Ireland could incorporate the recovery model into service delivery
- to prepare a discussion paper on the above for the Commission with a view to wider circulation as a discussion paper issued by the Commission.

This discussion paper is the result of this committee’s deliberations to date. It is based on an extensive literature review and contact with a number of personnel working in the mental health services in Ireland to ascertain the extent to which approaches to recovery have been incorporated into the Irish mental health services. The paper outlines the definitions and theoretical framework of the recovery philosophy, describes some of the international and Irish experiences in moving towards recovery oriented services and concludes with a summary of the core elements of a recovery-based model of practice to aid the discussion on its application within Irish mental health services.

The “recovery model” in mental health services 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. The recovery model does not seek to deny the neurobiological aspects of the major mental illnesses but promotes balance in terms of seeking a greater recognition that the experience of mental illness is inextricably intertwined with the individual’s sense of personhood and experience in the world. Clinical phenomena or symptomatology are part of the person’s intimate experience of being in the world and how the person negotiates his or her own experience of illness is likely to have a measurable effect on his or her progress towards recovery. The person’s attitudes, fears and hopes, their unique social
situation and their behaviour in respect of their own recovery must be integral to any comprehensive treatment model.

Interest in the recovery model for mental health services, has grown considerably during the last 15-20 years. Roberts & Wolfson (2004) have speculated that the recovery model is to some extent a rediscovery of psychiatric care and practices initiated almost two centuries ago by Tuke in York where clinical philosophy and therapeutic practice was based on kindness, compassion, respect and hope of recovery. Strong interest in incorporating the recovery philosophy into mental healthcare and in developing recovery orientated services is particularly evident in the United States, New Zealand and somewhat more recently in England. In the U.S. the recovery model is attracting the attention not only of mental health service users and service providers but is also engaging the interest of those who pay for services, to whom the prospect of enhanced results for their investment is obviously attractive (Ralph1999). Public policy on mental health in the U.S. has embraced the concept of recovery from mental illness. The Presidents' New Freedom Commission on Mental Health (2003) places the concept of recovery centre stage within a new transformed mental health care system in the U.S. The New Freedom Commission on Mental Health adopted the following vision statement:

“We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community.”

NFC 2003

More recently, in November 2003, at the annual conference of GROW in Dublin, the keynote speaker was Dr. Dan Fisher, Director of the National Empowerment Center, USA. (Dr. Fisher is also a member of the New Freedom Commission on Mental Health). The National Empowerment Center Inc. is a non-profit organisation staffed by people who have recovered from mental illness. Their mission is about hope, recovery and empowerment:-

“to carry a message of recovery, empowerment, hope and healing to people who have been labelled with mental illness. We carry that message with authority because we are a consumer-run organisation and each of us is living a personal journey of recovery and empowerment.”

(NEC, 2003)

Dr. Fisher met with members of the Mental Health Commission following this conference and expanded on the initiatives on empowerment and recovery being undertaken in the United States. Shortly after these events Roberts & Wolfson (2004) published a very comprehensive and thought provoking article in Britain titled “The rediscovery of recovery: open to all”, further stimulating the interest of the Irish Commission members.

The growing literature on recovery and recovery oriented mental health services has produced different definitions of recovery and some of these are explored in chapter 2. The evolution of the recovery model in the United States, Britain and New Zealand is explored in Chapter 3 before returning to a consideration of our own mental health services in Chapter 4.

The 1960s saw a radical change in how mental health services were provided in Ireland with the commencement of the de-institutionalisation of the large psychiatric hospitals. This represented a radical change in how mental health services were provided and many commentators then said “It can’t be done … it shouldn’t be done”. The commitment and foresight of those involved in Irish mental health care meant that this kind of radical change was in fact possible, that it could and did happen. The movement towards a recovery based model of service also represents an equally radical change in orientation. Progress in the process of de-institutionalisation and the development of community based service models has provided a foundation upon which a recovery-based model of service could be developed. This discussion paper aims to provide information, encouragement and support to services in the task of examining the implications of the recovery model for their service.
Chapter 2
Chapter 2

Definitions and Concepts

“Recovery is a process; a vision; a belief which infuses a system... which providers can hold for service users... grounded on the idea that people can recover from ‘mental illness’, and that the service delivery system must be constructed based on this knowledge...”

(Anthony, 2000)

In this chapter a number of definitions of ‘recovery’ and the recovery model of mental health are offered and the concepts associated with the recovery model are examined. As described earlier the development of recovery orientated services and practices is well advanced in a significant number of states in the U.S., in New Zealand and is at an earlier stage in the UK. In these jurisdictions there is some agreement that a recovery based approach has an essential role to play in shifting the emphasis in service delivery from a care model to one of enabling service users to reach their full potential in terms of both health and social gain. The recovery model too promotes a more optimistic viewpoint of the capacity for recovery from mental ill health. While recognising that persistent illness and impairment can be the experience of a proportion of people, the recovery model seeks to counter the uniformly pessimistic view of prognosis for those with severe mental illness.

“It has long been assumed that people with severe mental illness do not recover, leading to low expectations which have been seen to erode hope and collude with chronicity.

(Harrison and Mason, 1993)

Research findings in recent decades have shown good long-term outcomes for a majority of people with significant mental health difficulties. Perhaps the most well known study is the Vermont Longitudinal Study (Harding, Brooks, Ashikaka, Strauss and Breier 1987) which followed up a group of 269 people, resident in “wards” with an average of ten years of “total disability” and six years of continuous hospitalisation, who participated in a progressive rehabilitation programme and were then discharged to community based services. Although the shorter term follow up after ten years did not give grounds for too much optimism (two thirds of the group were living in the community but were heavily dependent on clinical services and tended to be socially isolated), the longer term follow up twenty to twenty five years after the index release showed that 55% by then attained a slight or no impairment rating and on the Global Assessment Scale 68% were judged to be functioning very well or recovered.

The WHO International Study of Schizophrenia (Harrison et al 2001) also studied outcomes at 15 and 25 years for people with a diagnosis of schizophrenia across several countries. Their results showed that over 56% of the ‘incidence’ cohorts and 60% of the ‘prevalence’ cohorts were rated as recovered. The outcomes for schizophrenia was somewhat poorer than for other psychoses across all measured
domains but the percentage rated as globally recovered was still close to 50%. There was also evidence of a late recovery effect in that 16% of subjects who had shown an earlier pattern of continuous impairment showed good outcome at 15 year follow-up. The occurrence of significant improvement after a long number of years of continuous impairment is an important research finding providing justification for long-term active rehabilitation programmes which continue to work for positive change even in the face of poor initial response to rehabilitation. In this respect Liberman and Kopelowicz (2002) caution that good results at any stage of rehabilitation are attained through sustained effort “Normal levels of psychosocial functioning and sustained periods of symptom remission cannot be reached through shortcuts. Rather clients, family members and practitioners will have to form partnerships to travel the long and hard road to organise and deliver services that are sustained, comprehensive, co-ordinated, collaborative and consumer-oriented”. The recovery movement is part of the drive towards collaborative and consumer oriented services.

Defining Recovery

“We saw a string of doctors who seemed as baffled as we were about prognosis or indeed on advice about what we could do to help ourselves. Their message seemed to be ‘the drugs have made you better, go out and be well’ in spite of the massive side-effects and the continued symptoms that were glaringly present”

(Mike Watts, Mental Health Service User, 2004)

The term ‘recovery’ as used in the recovery model has been variously described as a process, an outlook, a vision, and a guiding principle. It does not refer purely to the remission of clinical symptoms but is a wider concept which incorporates the person’s total adjustment to life. A recovery approach aims to “support an individual in their own personal development, building self esteem, identify and finding a meaningful role in society” (Allott and Loganathan 2003). Anthony (1993) describes recovery thus

“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 illness. Recovery includes the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”

Anthony 1993

Roberts (2004) points out that this definition implies that a person with mental illness can recover “even though the illness is not cured and that the process of recovery can proceed in the presence of continuing symptoms and disability.”
The recovery movement can incorporate a variety of personal and ideological standpoints with regard to illness and recovery and indeed the literature would suggest that there are differing ideological positions on issues such as the continued use of medication. For some people full recovery implies that medication is no longer necessary to maintain wellness. Dr Dan Fisher’s own experience has been that he does not require medication to keep symptoms at bay and he is anxious to share this experience, and to talk about the possibility of cure.

“\textit{I have recovered from schizophrenia. If that statement surprises you – if you think schizophrenia is a lifelong brain disease that cannot be escaped – you have been misled by a cultural misapprehension that needlessly imprisons millions under the label of mental illness}”

\textit{(Fisher, 2001)}

However recovery may also be achieved with the continued use of medication as part of one’s self management plan. In contrast with emphasising cure, Deegan (1988) defines recovery as an ongoing process \textit{“a way of life, an attitude, and a way of approaching the day’s challenges”}. How challenges are negotiated and what supports, including medication, the person may find efficacious for him or her is, according to the recovery literature, an individual decision.

The recovery model emphasises self-management and the developing of personal recovery strategies. Coleman (1999) emphasises that recovery is about taking personal responsibility:

‘\textit{Recovery is not a gift from doctors but the responsibility of us all … We must become confident in our own abilities to change our lives; we must give up being reliant on others doing everything for us. We need to start doing these things for ourselves. We must have the confidence to give up being ill so that we can start becoming recovered.”}’

\textit{Coleman 1999}

Since the experience of recovery from mental illness is necessarily individually defined and is much wider than the remission of clinical signs and symptoms there is an increasing need for researchers to develop more sophisticated outcome measures which reflect this broader definition of recovery. Indeed Anthony (2001) cautions that evidence based practice, because of the traditional narrowness of the outcome measures used to validate treatments, could serve to maintain traditional ways of delivering mental health services and fail to accept or validate newer, promising ways of delivering services such as recovery based services \textit{“Simple counts of employment - yes or no, hospitalisation - yes or no, are an enormous conceptual distance from what might be considered to be recovery outcomes”}. The debate about how to reconcile evidence based practice and the recovery paradigm continues in the U.S. and is returned to in Chapter 3.
The common themes underpinning definitions of recovery in the literature could be summarised as follows:

- ‘Living Well’ (perhaps despite the limitations of illness)
- Participating fully in our community
- Autonomy
- Self-Management and Responsibility
- Hope
- Personal Growth
- Person-centered services
- Resilience
- Empowerment

The literature is also clear that recovery is not a linear process; it is an individual process of small goals and achievable steps. Too often traditional psychiatric rehabilitation programmes have been viewed as linear and rigid in their guidelines. Deegan (1988) argued that

“the design of rehabilitation programme must be non linear i.e. with multiple points of entry and levels of entry into programming. The real challenge of rehabilitation programmes is to create fail-proof programme models. A programme is fail-proof when participants are always able to come back to pick up where they left off and try again. In a fail-proof environment where one is welcomed, valued and wanted, recovering persons can make the most effective use of rehabilitation services.”

Deegan 1988
Anthony (1993) in his review of the recovery literature summarised the common assumptions about the recovery process as follows:

<table>
<thead>
<tr>
<th>Table 1 - Assumptions about Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recovery can occur without professional intervention.</td>
</tr>
<tr>
<td>- Professionals do not hold the key to recovery; consumers do. The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumer’s natural support system.</td>
</tr>
<tr>
<td>2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.</td>
</tr>
<tr>
<td>- Seemingly universal in the recovery concept is the notion that critical to one’s recovery is a person or persons whom one can trust to “be there” in times of need.</td>
</tr>
<tr>
<td>3. A recovery vision is not a function of one’s theory about the causes of mental illness.</td>
</tr>
<tr>
<td>- Recovery may occur whether one views the illness as biological or not. The key element is understanding that there is hope for the future, rather than understanding the cause in the past.</td>
</tr>
<tr>
<td>4. Recovery can occur even though symptoms reoccur.</td>
</tr>
<tr>
<td>- The episodic nature of severe mental illness does not prevent recovery. As one recovers, symptoms interfere with functioning less often and for briefer periods of time. More of one’s life is lived symptom-free.</td>
</tr>
<tr>
<td>5. Recovery is a unique process.</td>
</tr>
<tr>
<td>- There is no one path to recovery, nor one outcome. It is a highly personal process.</td>
</tr>
<tr>
<td>6. Recovery demands that a person has choices.</td>
</tr>
<tr>
<td>- The notion that one has options from which to choose is often more important than the particular option one initially selects.</td>
</tr>
<tr>
<td>7. Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.</td>
</tr>
<tr>
<td>- These consequences include discrimination, poverty, segregation, stigma, and iatrogenic effects of treatment.</td>
</tr>
</tbody>
</table>

*Adapted from Anthony (1993)*
Personal Narratives

“Everyone has a story and it is unique. A complex mosaic studded with people, experiences and events over many years results in a personal history that is far from simple. No amount of detail or analysis can fully exhaust the mystery of any one of us”

(Stan, Soul Survivors, GROW, 2003)

The Recovery literature places a particular value on personal narrative, on people writing their own story, explaining their own unique journey towards recovery and what helped or hindered on that journey. These personal narratives can be very powerful in de-mystifying the experience of illness and focusing on the person’s strivings to achieve his/her personal goals. People who have recovered or are recovering from mental illness are very vital sources of knowledge about the recovery process. This is well recognised by organisations such as GROW and also Schizophrenia Ireland where people may describe themselves as gaining valuable knowledge about schizophrenia through “self-experience”.

Organisations which facilitate recovery

“This nurse encouraged my self-determination and independence, outlining employment and training options down the road. With such progressive input I felt no longer like a number but someone who had a real chance of having a happy and challenging future”

(Diarmuid Ring, Mental Health Service User, 2004)

The attitudes of staff and indeed attitudes throughout the organisation are very important in shaping environments which facilitate recovery. Environments which can support people in developing and implementing their own individual plans for recovery, which can not only accommodate but encourage personal preferences and which allow the person to take some “risks” in moving forward are, the literature suggests, more facilitating of recovery.

“Recovery requires the right atmosphere or organisational climate in your mental health organisation - one that is sensitive to consumers and values independence of the individual. It allows consumers to risk, to fail. It holds that every consumer has a right to the same pleasures, passions and pursuits of happiness that we have. It looks at potential not deficits.”

Weaver, 1998
The British Department of Health’s 2001 Policy Document “The Journey to Recovery” also emphasises the role of the mental health service in facilitating personal choice “the mental health system must support people in settings of their own choosing, enable access to community resources including housing, education, work, friendships or whatever they think is critical to their own recovery”.

In New Zealand a list of competencies for staff working in the mental health services has been developed based on the recovery model. The New Zealand Mental Health Commission (2000) has stated that these competencies are not simply an add-on to current thinking but require a radical change in training. The competencies which staff need to acquire include:

- understanding recovery principles
- equality and social inclusion
- self-determination
- supporting the service user and family

Recovery and the Medical Model

In the literature the recovery model is often juxtaposed with the “medical model” which term is used as an umbrella term for traditional medical thinking. Roberts (2004) speaking of the recovery perspective and the traditional medical model of mental illness states that “these two perspectives, their values and language, stand in significant tension with one another (see Table 2). While a certain creative tension between approaches is often useful in promoting debate and sharpening and fine tuning theoretical positions, the polarisation of these two approaches is likely to prove ultimately unhelpful and an integrated perspective, respecting the contribution of each is likely to provide a way forward for the development of effective services.
Table 2 - Difference in concepts, language and values between the recovery and the traditional medical model of mental illness

<table>
<thead>
<tr>
<th>RECOVERY MODEL</th>
<th>MEDICAL MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distressing experience</td>
<td>Psychopathology</td>
</tr>
<tr>
<td>Biography</td>
<td>Pathography</td>
</tr>
<tr>
<td>Interest centred on the person</td>
<td>Interest centred on the disorder</td>
</tr>
<tr>
<td>Pro-health</td>
<td>Anti-disease</td>
</tr>
<tr>
<td>Strengths-based</td>
<td>Treatment-based</td>
</tr>
<tr>
<td>Experts by experience</td>
<td>Doctors and patients</td>
</tr>
<tr>
<td>Personal meaning</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Understanding</td>
<td>Recognition</td>
</tr>
<tr>
<td>Value-centred</td>
<td>(Apparently) value-free</td>
</tr>
<tr>
<td>Humanistic</td>
<td>Scientific</td>
</tr>
<tr>
<td>Growth and discovery</td>
<td>Treatment</td>
</tr>
<tr>
<td>Choice</td>
<td>Compliance</td>
</tr>
<tr>
<td>Modelled on heroes</td>
<td>Underpinned by meta-analysis</td>
</tr>
<tr>
<td>Guiding narratives</td>
<td>Randomised controlled trials</td>
</tr>
<tr>
<td>Transformation</td>
<td>Return to normal</td>
</tr>
<tr>
<td>Self-management</td>
<td>Expert care coordinators</td>
</tr>
<tr>
<td>Self-control</td>
<td>Bringing under control</td>
</tr>
<tr>
<td>Personal responsibility</td>
<td>Professional accountability</td>
</tr>
<tr>
<td>Within a social context</td>
<td>Decontextualised</td>
</tr>
</tbody>
</table>


General Practitioners and other primary care staff who work with people within their own communities often have perhaps a keener appreciation of the central role of selfcare for people in managing and alleviating illness. The World Association of Family Doctors (WONCA) give due prominence to self care in their model of healthcare systems. (WONCA 2002) This is reproduced in Appendix 1.
Criticisms of the Recovery model

Perhaps because of its relatively recent arrival a survey of the literature has not yielded a great deal of critical analysis of the recovery model and there is, as yet, a paucity of well controlled research studies comparing recovery based services with services run on more traditional lines. The recovery model appears to have acquired its strength to a large extent from its resonance with service users and many clinicians rather than from rigorous testing at this point in its development. However some researchers and clinicians have taken a cautious approach to the recovery model. Some clinicians who are sceptical about the possibility of recovery from schizophrenia have suggested that some of those who have been vocal about their recovery from schizophrenia had in fact not been accurately diagnosed initially (Fisher, 2003).

Liberman and Kopelowicz (2002), who consider that a target of recovery for 50% or more of persons experiencing first episode schizophrenia is realistic at this point, emphasise that individuals will differ significantly in terms of severity of schizophrenia and will respond differently to even the best of the available treatments and that severe disability will persist for a certain proportion of individuals. "No one should be put into a mind-set of feeling guilty or inadequate - researcher, administrator, clinician, consumer or advocate - when refractoriness to treatment is associated with persistent symptoms and severe disability in a certain proportion of cases"(p.246).

Whitwell (1999) is sceptical about the defining of recovery in any way other than the conventional medical definition of recovery which defines recovery as involving the restoration of a former state of health. He points out that in his own research on recovery it proved difficult to access subjects who actually demonstrated full recovery by this conventional definition. Those who came forward describing themselves as recovered had not attained a full return to their former life and he was reluctant to accept them as qualifying to be described as recovered. "They were more careful, less confident, more aware of danger. A few saw this change in a positive light, saying they were now more genuine, more their real self, more sensitive to people. However the feeling of ‘not being the same’ was felt to be inconsistent with the concept of recovery. The subjects were also highly conscious of their impaired life position following their psychiatric illness". However, the recovery model clearly works outside the conventional definition of recovery and stresses the individual nature of definitions of recovery.
Chapter 3
Chapter 3

Some International Experiences of Developing a Recovery Based Approach

The international mental health literature evidences a strong interest in the incorporation of recovery concepts into the organisation and delivery of mental health services in several countries notably Britain, the U.S. and New Zealand. Some other countries such as Australia have included consumer and carer involvement in service planning and delivery in their national mental health strategies but have not yet made substantial progress in terms of implementation (Whiteford, Buckingham and Manderscheid 2002). The incorporation of recovery concepts has proceeded somewhat differently in Britain, the U.S. and New Zealand because of its somewhat different origins in each jurisdiction. Particular elements of the recovery philosophy have found expression in somewhat different ways in these different health systems. This chapter will attempt an overview of the development of recovery orientated services across each of these health systems.

Developments in Britain

In Britain a number of strands of development have contributed to the growth of a recovery philosophy within their mental health services.

Department of Health Mental Health Policy Documents

The UK’s Department of Health’s report on its mental health services in 2001 entitled “The Journey to Recovery” has been referred to earlier. It drew together the Department’s policies for mental health as developed over a number of health policy documents. Elements of the recovery model are expressed throughout the document. It emphasises the involvement of people who use mental health services “as equal partners and at every level to ensure the new services make sense.” Importantly some of the document uses the language of “we” rather than “they” so that its authors do not distance themselves from mental health service users as has been customary in mental health literature, e.g. “If we are under thirty five and have developed psychosis” and “If our problems are so acute that we could require admission to hospital”. It stipulates that all mental health services “will be expected to recruit and train service users as part of the workforce”. It also recognises the central importance of information for all decision makers including users and carers.

In 2002, the NHS’s National Institute for Clinical Excellence (NICE) published clinical guidelines on the treatment and management of schizophrenia emphasising optimism about treatment outcomes, partnership with service users and carers and the importance of good information and mutual support. They caution about the overuse of clinical language. (In this context Roberts and Wolfson (2004) suggest that a more recent Department of Health UK guideline on copying letters to patients will oblige psychiatrists, in common with all doctors, to write in a way that patients can readily and usefully understand.) The NICE report gives a position of importance to the individual’s experience of his/her illness and the need for health professionals to try to develop an understanding of that experience. It recommends that, where practical, service users be encouraged to write their own accounts of their illness for their case notes.
The Expert Patient Initiative

The UK’s National Health Service has developed a model of partnership between service users and health professionals in the management of chronic illness through an initiative called the “Expert Patients Initiative.” Their 2001 Task Force report “The Expert Patient” advocates the development of patient self-management programmes for chronic diseases including mental illnesses such as bi-polar illness. The report is clear that this initiative represents a fundamental shift in thinking about chronic illness management. It moves beyond conventional thinking which limited patient involvement essentially to instructing patients about their condition and measuring the success of the instruction in terms of treatment compliance. The focus is instead on programmes which develop the confidence and motivation of patients with a chronic illness to use their own knowledge and skills to take control of their lives with a chronic illness. The report describes several models of user led self management programmes for chronic illnesses such as diabetes, arthritis and multiple sclerosis and also describes a Self Management Training Programme for manic depression (SMTP), a user developed and user led programme begun by the Manic Depression Fellowship in 1998, based on an Ohio programme.

The Recovery Debate

The recovery movement in Britain has also been influenced by the more optimistic picture emerging from long term follow up studies of people experiencing schizophrenia. Some mental health professionals who have themselves recovered from psychosis have published the stories of their own recoveries (Chadwick 1997, May 2000). The role of self-help is being explored in Britain notably by Allott and Loganathan (2003) who consider that self-help is not about developing generalised coping techniques which will apply to a particular clinical group or people with similar difficulties but about developing individual strategies within the context of the individual’s complex biography/narrative. In Britain also, developments in the area of cognitive psychology by Morrison and others (Morrison & Rentan 1998, Morrison 2001) have led to the provision of programmes of cognitive therapy aimed at helping people to deal with some of the central symptoms of psychosis such as delusional thinking using cognitive behavioural techniques, usually in conjunction with pharmacotherapy. This work is not only providing a new set of therapeutic techniques, facilitating symptom management and increased personal control but is also helping to erode the notion of a qualitative difference between ‘psychotic’ and ‘normal’ thinking patterns, further contributing to the normalisation of the experience of psychosis.
Recently Roberts and Wolfson (2004) in their review of the recovery literature have attempted to provide an overview of the recovery movement and its implications for the mental health services in Britain. They delineate “steps” for health service providers in moving towards recovery orientated practice.

These steps involve:

- A shift of professional role from authority figure to a role more akin to a coach or personal trainer
- Developing hope inspiring relationships with service users
- Matching the timing of responses to the persons need particularly in the area of insight
- Working with users in a negotiation framework with regard to reaching agreement on medication (The Expert Patient Report (2001) uses the term “concordance” to describe an agreement reached after negotiation between patient and health professional)
- Being willing to accommodate the service user’s right to take risks and even to experience failure, recognising that without some risk there is no progress.

A recovery based service for Roberts and Wolfson (2004) promotes self-management and allows hospitals to function as a ‘springy safety net’. It incorporates the lived experience of users into staff training, recognising patients as experts in their own experience as in the “Expert Patient Initiative” (2001). It values ethnicity and diversity and the importance of the person’s cultural origins and personal meanings. The recovery model for Roberts and Wolfson (2004) also involves a willingness in health professionals to share and benefit from their own personal experiences of mental ill-health, thus eroding the traditional divide between patient and professional. They also underline the importance of occupational activity to recovery.

**Developments in the United States**

The American mental health system began to incorporate the concept of recovery in the nineties, rather earlier than some other health systems, and more recently the U.S. Surgeon General has endorsed the concept of recovery as being central to U.S. mental health policy (Ralph, Lambert and Kidder 2002). A number of strands have contributed to the development of a recovery culture in the U.S. Some of the more important of these are the more optimistic research findings regarding recovery rates from serious mental illness, the growth of a strong consumer movement, and the development of self-management programmes in healthcare. These influences are discussed and an attempt is made to describe some of the important aspects of the roll out of the recovery model across the U.S.
Optimism about recovery

The more optimistic picture emerging from long-term research in the U.S. into recovery rates for severe mental illness gave an impetus to the movement towards a more positive ethos in mental health service provision. It came to be more acceptable to talk of recovery from mental illness as an alternative to inevitable life long disability of varying degree (Ralph, Lambert and Kidder, 2002).

In addition, some people who had recovered from serious mental illness including health professionals such as Dr Dan Fisher, a psychiatrist, referred to earlier (1994, 1996), and Dr Patricia Deegan (1988, 1993, 1996), a clinical psychologist, (both of whom had previously been hospitalised for schizophrenia), began to write about and discuss their individual experiences of illness and recovery. These highly visible “consumer survivors” represented very real sources of hope and inspiration to those who had experienced schizophrenia and also a very visible challenge to colleagues in the mental health field who had not taken on board the more positive long-term prognosis emerging from the research studies. Deegan (1993) herself laments the lack of positive role models during her long period of hospitalisation.

“It would have greatly helped to have had someone come and talk to me about surviving mental illness as well as the possibility of recovering, of healing, and of building a new life for myself. It would have been good to have had role models—people I could look up to who had experienced what I was going through—people who had found a good job, or who were in love, or who had an apartment or house on their own, or who were making a valuable contribution to society”.

(Deegan, 1993)

Bassman (2001) a licensed psychologist who experienced schizophrenia is also aware of the value of his story to others who need hope.

“I choose to speak and write about my experience so that others who have been diagnosed and treated for serious mental illness will be able to see new hope and possibility”

(Bassman 2001)
The published stories of health professionals who have experienced serious mental illness and recovery are helping to erode the artificial barrier between ‘professional’ and ‘patient’, between service user and those working within the mental health services. This has been a theme in the writings of ‘consumers survivors’ in the U.S. who stress the need for mental health workers to acknowledge a common humanity in order to be truly helpful. “The worker and consumer engage in an I-Thou relationship, and not a subject-object relationship. In this state of humanisation the worker realises that, at another time, his/her role could be reversed” (Schiff 2003 p.214). In similar vein Deegan 1988 pointed out that

“too often staff attitudes reflect the implicit supposition that there is ‘the world of the abnormal’ and the ‘world of the normal’ … such an attitude places staff in a very safe position in which they can maintain the illusion that they are not disabled, that they are not wounded in any way, and that they do not need to live the spirit of recovery in their own life.”

Deegan 1988

Fisher (2003) too during his visit to Ireland stressed the importance of human connection for recovery considering that “people can and do yearn to connect emotionally especially when they are experiencing severe emotional distress” (Fisher, 2003).

Self-help Movements

The recovery movement in mental health in the U.S. has undoubtedly benefited from the existence of a strong generic self help movement, as exemplified by Alcoholics Anonymous and other similar groups. These movements emphasise mutual support and also give a privileged status to personal stories of recovery as a powerful source of hope and help to others.

Recovery Inc. was founded in 1937 by Abraham Low, a psychiatrist, for his patients and uses a method called ‘will training’. Group members aim to replace faulty cognitions and emotional habits with the trained will. The commonly used saying “feelings are not facts” is a Recovery Inc. slogan.

The GROW movement, which developed in Sydney in 1957, was imported to the USA and became a part of the movement towards a more positive recovery orientated philosophy of mental illness. The GROW programme in particular has been subject to rigorous evaluation in the U.S. and has shown consistently impressive results. Rappaport and his research team at the University of Illinois undertook a large scale longitudinal study of the GROW programme interviewing members at 1, 3, 9, 15, 21 and 27 months after joining the programme. The research showed significant gains in terms of social networks, higher rates of current employment, lower levels of psychopathology and higher levels of personal adjustment (Rappaport et al 1985). A further study by Kennedy (1989) of
hospitalisation rates in GROW and non-GROW attenders showed that, in a sample matched for demographic details and rates of prior hospitalisation, there were quite remarkable differences in the rates of subsequent hospitalisation in favour of GROW attenders i.e. an average of 49 days as compared with 123 days in hospital for the matched control group.

The concepts of self-help and peer support from other service users or “consumers” are integral to the recovery model. In this connection Anthony (1993) considers that a model of service promoting only professional help is neglecting a huge and valuable resource for service users. Indeed he is clear that recovery does not necessarily require professional intervention “Recovery can occur without professional intervention. Professionals do not hold the key to recovery, consumers do” (p.18).

In the forensic mental health services too in the U.S. there is a growing recognition that the involvement of service users who have recovered is a powerful tool in delivering hope. Starr (2000) in his collection of essays “Not guilty by reason of Insanity” writes frankly about how his illness eventually led to matricide and details the process of his recovery as an aid to others in the forensic mental health system.

“[The bottom line is that like so many of my forensic and corrections brothers and sisters, I am not a bad person, but merely a person who has done bad. I have had others spit on me while I was suffering while at the same time I spat on others who suffered. I have much empathy towards the demented and the wretched, mainly because I have been both ... I can clearly read the writing on the wall because I have written on that wall”

Starr, 2000

Deegan (1996) uses the language of the self-help movement in describing her own progress towards recovery from schizophrenia. “We rebuilt our lives on the three cornerstones of recovery - hope, willingness and responsible action.”

The development of self-management programmes in healthcare

The U.S. has also experienced, as in the UK, the development of self-management programmes for chronic physical illness. These programmes put the service user’s experience and knowledge centre stage. The Chronic Disease Self-Management programme, developed at Stanford University, California and designed to be taught by tutors who themselves have chronic illness, has been widely adopted across the U.S. and in Europe, Australia and China. In parallel a large number of self-management programmes were also developed for the use of people with mental health difficulties.
Fisher (1998) defines self-managed care in mental health thus

“Self-managed care is consumer directed, multi-level, strength-building planning to genuinely assist a person to gain a meaningful role in society. This planning is contrasted to maintenance-based treatment planning which by its nature is professionally directed to correct pathology.”

Fisher 1998

The Recovery Workbook (Spaniol, Koehler and Hutchinson, 1994) is a programme developed at Boston University. The workbook is accompanied by a Leaders Guide (Spaniol, Koehler and Hutchinson, 2000) and a collection of individual recovery testimonies. It is designed as a 30 week group programme to be facilitated by two people at least one of whom has experienced mental health difficulties but is in recovery.

Ellen Copeland (1992, 1997, 1999) who had personal experience of depression, developed a number of self-help programmes using information from groups of service users reporting their coping strategies. The “Wellness Recovery Action Plan” programme known as WRAP (Copeland 1997) which helps individuals to develop their own “wellness tools” and develop their own written plan to deal with disabling symptoms and maintain wellness has been disseminated widely across the western world and is used by some mental health services in Ireland notably the Health Service Executive Mid-Western area.

In Tennessee the BRIDGES programme is a recovery education programme which grew out of consumer research (Knight (2000), Tennessee Mental Health Consumers Association (1999)) and it is used extensively across the state. Class leaders are always service users and the programme is designed to be delivered in weekly classes over 15 weeks.

Individuals can also access some treatment/self care programmes offered in manual form. Bourne and Bourne (1995) developed the “Anxiety and Phobia Workbook”, a self help programme for people with anxiety disorders. Greenberger and Padesky (1995) developed a self-help cognitive therapy manual for people experiencing depression. These manuals can be used with or without professional assistance.
Rolling out Recovery in the U.S. mental health services

“First, services and treatments must be consumer and family centred, geared to give consumers real and meaningful choices about treatment options and providers - not oriented to the requirements of bureaucracies.”

Second, care must focus on increasing consumers ability to successfully cope with life’s challenges, on facilitating recovery and on building resilience, not just on managing symptoms”


The literature describes a large number of state-wide recovery initiatives in different states in the U.S. (Anthony 2000, Ralph et al 2002), including Ohio (Beale and Lambric1995), Illinois (Barton 1998) and Wisconsin (Blue Ribbon Commission 1997). The process has not been uniformly successful in introducing a recovery ethos across services. Jacobson (1998) was commissioned by the Blue Ribbon Commission in Wisconsin to conduct telephone interviews with key staff in twelve states to gather data on how the concept of recovery was being implemented in their state mental health systems. She reported that different states were at different stages in planning and implementation and some states were making more radical shifts in redesigning services than others. Jacobsen and Curtis (2000) commenting on the findings of this survey point out that, unfortunately, some states “with revision statements in hand” were simply renaming their existing programmes so that community support services, vocational rehabilitation or housing support were renamed as recovery orientated services. “This renaming process demonstrates a lack of understanding of recovery; in particular, a failure to acknowledge the necessity for a fundamental shift towards both power and responsibility”.

Anthony (2000) describes a set of recovery orientated system standards developed at the Boston University Centre for Psychiatric Rehabilitation. These encompass:

- Service design driven by recovery vision
- Systems of evaluation using measurable and observable consumer outcomes
- Leadership which reinforces the recovery vision and recovery standards
- Management policies focusing on service processes rather than on staffing or the physical setting
- Integrated case management
- Comprehensive supports across environments
- Consumer involvement
A Vision for a Recovery Model in Irish Mental Health Services

3

- Cultural relevance
- Advocacy training grounded in the vision of recovery
- Funding based on consumer’s recovery goals
- Access to services based on consumers goals.

An interesting debate has also begun in the U.S. about the relationship between the recovery model and evidence based practice. It is being argued that a difficulty arises in fitting recovery orientated services into a evidence based framework. Evidence based practice relies on empirical evidence of the effectiveness of treatments or services and what constitutes acceptable evidence depends on the framework which is used to evaluate practice and outcome. Thus far that framework is based primarily on a medical model of mental health difficulties and outcomes are defined almost solely in those terms e.g. in terms of reduced symptomatology or reduced service use (Anthony, 2001). For this reason authors such as Caras (2002) consider that the evidence based paradigm leaves out evidence which is important to the recovery movement. There is also a fear that evidence not fitting existing paradigms may be discounted. “When we who are most directly affected tell our stories, recovery is dismissed as wrong diagnosis, and discomfort with medication is called non-compliance”.

Developments in New Zealand

“The recovery model has been enthusiastically embraced by the mental health services and the Mental Health Commission in New Zealand and New Zealand services have been based on a recovery centred blueprint since 1998 (Mental Health Commission NZ 1998). The New Zealand Mental Health Commission’s 2001 document “Recovery Competencies for New Zealand Mental Health Workers” elaborates the recovery principles set out in their 1998 blueprint and describes the set of competencies it considers mental health workers need to acquire to work within a recovery orientated service. They are clear that the incorporation of these competencies into training represents a fundamental change in all aspects of the education of mental health workers.”

These competencies stress:

- The understanding of recovery principles
- Supporting personal resourcefulness of service users
- Accommodating diverse views of mental illness
- Communicating respectfully and developing good relationships with service users
- Understanding and actively protecting user’s rights
- Understanding discrimination and social exclusion and how to reduce it
- Acknowledging the different cultures of Aotearoa/New Zealand
- Knowledge of community resources
- Comprehensive knowledge of the service user movement and support of their participation in services
- Knowledge of the family/whanau perspectives and support of their participation in services.
- The Recovery Competencies emphasise fostering personal resourcefulness and human resilience and strength rather than focusing on deficits.

A comprehensive set of educational materials, in the form of a “Recovery Competencies Teaching Resource Kit” has been developed to teach these competencies to mental health workers. These are likely to prove an invaluable resource to health services from other countries who are moving towards a recovery model of service. The teaching resources pack draws on a wide variety of materials including recovery literature from the U.S., materials from self help organisations such as GROW, literature from psychiatric rehabilitation studies and a large store of recovery oriented teaching materials developed by service user groups and the New Zealand mental health services. One such handout developed by a service user group is reproduced fully in Table 3.
Table 3
To Mental Health Professionals – A Consumer Perspective on Partnership

Mental Health professionals need to KNOW that:

- we are individuals with unique experiences
- we respond well to being treated with respect and accorded our basic human rights
- we respond well when we are listened to and understood (even when we are scared and angry)
- we respond well to having our concern taken seriously, for example when our concerns about medication side effects are properly addressed
- our health improves more quickly if we are calmed rather than restrained
- we can manage our illness better if we are educated about it
- we can manage our illness better if we are given some help in identifying the issues in our lives that cause us stress
- we find it easier to manage our illness if we know about the kind of support groups that are available in the community
- we can participate more fully in the community if we are given some assistance with our social needs
- we can be assertive in our communities if we know our rights.

(This document has been developed by consumers in the Southern Region of the Project to Counter Stigma and Discrimination Associated with Mental Illness.)

The Mental Health Foundation, PO Box 13 167, Christchurch.
Service users have been assisted by the New Zealand Mental Health Commission to produce a user friendly guide to mental health services. This guide advises service users to take a proactive role in their own recovery.

“Ask your mental health worker about their role and how they can help you.
Tell them what you need.
Tell them you want to be fully involved in decisions about your treatment and care.
Bring your family and friends to appointments if you think they will help.
Ask your mental health worker to explain your mental health problems to family and friends who don’t understand.
Ask to see another mental health worker if you don’t get on with your present one.”

(Oranga Ngakau 2003)

The New Zealand Mental Health Commission has recently supported a service user publication “Our lives in 2014” (2004) in which people with experience of mental illness, referred to by themselves as “tangata motuhake” ¹, express their views to the Ministry of Health on what should form part of the blueprint for a recovery oriented mental health service for the next ten years. The document is very clear that services should be provided in ways that keep people connected to their own communities and that services need to cross agency and sectoral boundaries to ensure a good service. The document further suggests that mental health services should provide safe and effective resources and solutions and include:

- psychological therapies
- support services, including practical assistance
- support for philosophical reflection
- traditional and cultural healing
- alternative and complementary therapies
- psychiatric drugs that work for us
- a choice of home, community or hospital based acute services
- advocacy services.


¹ “Tangata motuhake is a term for people with experience of mental illness or distress, chosen by us. It means special or unique person and can be loosely translated as ‘cherish your absolute uniqueness’.”
A Vision for a Recovery Model in Irish Mental Health Services
Chapter 4
The Recovery Model and Irish Mental Health Services

“A quality mental health service is one which encompasses the following … Facilitates respectful and empathetic relationships between people using the service, their families, parents and carers, and those providing it. Empowers people who use the mental health services and their families, parents and carers ... Is accessible and equitable ... Is provided in a high quality environment which respects the dignity of the individual, his/her carers and family ...”

Quality in Mental Health - Your Views, Mental Health Commission (2005)

One of the most important policy documents in Irish healthcare in recent years, the Health Strategy of 2001, emphasises a holistic view of the person and advocates a partnership model of healthcare. It adopts the WHO definition of health as “a complete state of physical, mental and social well being and not merely the absence of disease or infirmity”. Developing a “people centred” health system is a central aim of the health strategy. A people centred health system is defined as one which:

- Identifies and responds to the needs of individuals
- Is planned and delivered in a co-ordinated way
- Helps individuals to participate in decision making to improve their health

(Quality and Fairness, A Health System for You, Health Strategy (2001))

The Health Strategy seeks to move the health service, including our mental health services, towards a more inclusive and participative model of healthcare.

Other key documents in Ireland which have challenged society's attitudes are “A Strategy for Equality” (1997) and the more recent “Learning for Life: White Paper on Adult Education” (2000).

“A Strategy for Equality” (1997) questions why people with a disability are excluded from almost every aspect of economic, social, political and cultural life in Ireland. The document considers that people are entitled to “equality and full participation as citizens”. The key principle that underlies all the recommendations in the report is the principle of equality of access to housing, sport, leisure and education. Its conclusions have very strong echoes within the recovery literature.

The White Paper on Adult Education (2000) also identifies equality of access as one of the three core principles underpinning the strategy “Promoting ... equality of access, participation and outcome for participants in adult education, with pro-active strategies to counteract barriers arising from differences of socio-economic status, gender, ethnicity and disability. A key priority in promoting an inclusive society is to target investment towards those most at risk;” In the area of mental health this involves ensuring that mental health service users have equal access to mainstream
education opportunities, to courses of study which are accredited and where the person develops a student identity.

At the recent HOPE Conference (Dublin February 2005) Dr. Pat Bracken (Consultant Psychiatrist) proposed that a new paradigm in mental health should have its primary focus on citizenship. A person should be allowed to have a positive societal identity with the freedom to define one’s own identity. At the same conference Dr. Teresa Carey (Inspector of Mental Health Services) also advocated for “respect for the user as a citizen with the right to be involved in care planning and treatment decisions” (Carey 2005).

Ireland’s mental health services have been exposed to the recovery model only in very recent years and for the most part have not yet taken on the challenge of incorporating the recovery philosophy into the organisation and delivery of services. As described earlier, recovery orientated services cannot be achieved by a minor degree of re-orientation or re-labelling of existing services (Jacobson and Curtis 2000). The recovery model implies a fundamental shift in how services are organised and how responsibility, information and indeed power are shared within services. Anthony (1993) speaks of the stages of development of the mental health system in the USA moving from de-institutionalisation to the establishment of community supports and rehabilitation services and then towards a further stage which is the development of recovery based services. The Irish mental health services are by and large struggling with the last stages of the de-institutionalisation process and the establishment of comprehensive community support services and many services may feel they have as yet had little opportunity to look towards what future may be ahead.

To date the participation of service users in the planning and organisation of services is rare and recent surveys such as the Pathways Report (2002), the Mental Health in Primary Care Report, the “Quality in Mental Health-Your Views” (MHC, 2005) and the Expert Mental Health Policy Group consultation document “What We Heard” (2004) suggest that very many users experience our mental health services as pharmacocentric and often personally disempowering. We are aware, however of a number of initiatives throughout the country, many of them small scale projects, which demonstrate elements of the recovery philosophy in their mode of operating and in their relationships with their service users. Some of these initiatives involve the statutory services and many of the initiatives happening outside the statutory services are perhaps receiving some statutory funding. Only a small number of examples can be mentioned here.

Examples of movement towards a recovery ethos in statutory services include the innovative relapse prevention programme developed by the social work department within the mental health services in the Mid West based on Copeland’s (1992, 1997, 1998) WRAP programme. Evaluations of the Mid West programme have shown that participants value having access to information about their illness and about how to identify their relapse signature and triggers. The groups discuss whatever issues the participants feel are relevant including stigma, dealing with “voices”, employment, relationship and family issues, isolation and social exclusion in addition to sharing self-management strategies.
The Dublin South City's mental health service has developed a number of innovative group programmes under the auspices of its clinical psychology service, addressing people’s experiences of mental health difficulties within a group context in a way that is participative and positively affirming. These involve a long running group therapy programme for people in the acute admissions ward at St James Hospital providing a forum within which people can articulate and share their personal experience of being an in-patient, a relapse prevention programme within a framework of mindfulness-based cognitive therapy and a “Staying Well” group programme encouraging self-management where leadership is rotated between participants.

S.T.E.E.R. organisation operates in both Northern Ireland and the North West of Ireland, delivering a range of support services for people with mental health difficulties. S.T.E.E.R. recognises that up to 90% of people with mental health difficulties are unemployed and that access to housing is a very significant problem. The organisation’s services include access to education, including a training programme called ‘Supported Recovery Program’ which focuses on personal development and capacity building, community outreach and Advocacy. S.T.E.E.R. is looking towards offering alternatives to hospital care such as a “Recovery House”, step down facilities and supported housing. S.T.E.E.R. has a very developed recovery philosophy in the form of the ‘Recovery Model’ to which the Organisation adheres to and which informs its different operations. Some of the S.T.E.E.R. literature is reproduced in Appendix 2.

The Pathways project was a unique research project designed, conducted and completed by a project group of mental health service users which explored service users experiences of the mental health services in Galway City. The project was supported by the mental health services and by Schizophrenia Ireland and resulted in the publication of the Pathways Report in May 2002. Members of the project group remark on the personal growth associated with being part of this project group.

“Joined Pathways after a long history of involvement with the West Galway Mental Health Services and found the experience to be extremely empowering and liberating. The process of Mapping our Pathways allowed me a chance to examine my own history with the service, to hear what others had experienced, and to deal with, and process, the anger, sadness, and loss in my life that were consequences of my illness”

(Pathways Report, 2002)

Outside the statutory services, some voluntary bodies have sponsored service innovations which have elements of the recovery philosophy. The setting up of Clubhouse in Ireland is one such initiative. A Clubhouse is an enterprise which brings together people who have experienced mental health difficulties in a mutually supportive environment and the clubhouse philosophy is that every individual has something valuable to contribute to the clubhouse and to society at large. Clubhouse was first set up in Ireland under the auspices of EVE in Newbridge, Co.
Kildare in 1999 and subsequently in Clondalkin and in Blanchardstown and in Sligo. Some other initiatives based on a positive view of the individual’s capacity for recovery have been developed under the auspices of Mental Health Ireland including Cluain enterprises in Clonmel providing individually tailored training opportunities for people with mental health difficulties and Le Chelle in Limerick which was set up to provide a supportive and relaxed meeting place for people who had experienced mental health difficulties and their families and friends. There are many more examples of innovation around the country, often on a small scale, by dedicated groups of mental health care staff and committed voluntary groups whose vision for mental health encompasses a positive recovery orientation.

Many of the existing initiatives within Irish services, particularly those in the training or occupational area, have their philosophical roots in the social model of disability. This model, which is espoused by the National Disability Authority (NDA, 2003), locates disability within society and in how society functions and adapts to disability. The social model of disability is often contrasted in the literature with the more traditional medical model of disability which locates the disability in the person in terms of a deficit or deficits. The National Disability Authority is a strong advocate of service users being represented as equal partners in decision making in services, both as users and as contributors to strategic development (NDA, 2003).

Self-Help Groups

“Whatever the trouble is it is one of those things that can and do happen to human beings”.

The Bedrock Principle, (GROW, 2001(Blue Book))

Self help groups in Ireland, in common with their counterparts in other countries, have developed ways of working which exemplify the most important aspects of the recovery model. The GROW movement places particular emphasis on the importance of self-management and of pursuing an individual path towards one’s own recovery. As in AA the GROW programme has 12 steps for recovery and personal growth. Like the recovery model of services it stresses the resilience of the human being and the importance of mutual help, and of supporting others in addition to being helped oneself. It is a programme based on a belief in recovery “I can, and ultimately will, become completely well”. A study commissioned at the Department of Applied Psychology in University College Cork to evaluate GROW’s leadership programme showed positive gains in leadership skills and confidence for participants (Dunne and Meehan, 2002). GROW has produced two publications called Soul Survivors, Volume 1 and 2 (1995, 2004) comprised of personal accounts from people who experienced serious mental health difficulties and have found their own individual paths towards recovery.
Schizophrenia Ireland, which offers a variety of support services to service users and their families, has been a strong advocate for the participation of service users not only as partners in the development of their own individual treatment programmes but in the planning of services, as experts by experience with an important voice. Its 2003 submission to the Government appointed Expert Group on Mental Health Policy expresses the view that

“In setting out a mental health strategy for future service delivery it is vital that services are re-oriented towards partnership and recovery and that recovery is viewed as the overarching objective for mental health policy”

(Schizophrenia Ireland 2003)

This submission also suggests that the language of psychiatry needs to be reviewed and terms such as ‘acute’, ‘treatment’ and ‘mental illness’ re-formulated to encourage more holistic and inclusive views of people with self-experience of mental illness.

The relatively new Irish Advocacy Network which staffs its advocacy service with service users also incorporates important aspects of the recovery model in its philosophy. It incorporates a recognition that “severe emotional distress forms a part of the existential act of living and therefore anyone could be labeled as mentally ill at some point in life”. The normalisation of emotional distress, as also seen earlier in the GROW “Bedrock Principle”, is an important aspect of the recovery model. In a very concrete way advocates who have been or are service users provide direct evidence to those seeking help that recovery is possible. The Irish Advocacy Network considers self-determination to be essential to recovery and describes the experience of traditional models of care as invasive and stigmatising.

We are also fortunate in Ireland to have Bodywhys, Aware and Recovery, support organisations whose programmes emphasise self-help and mutual help.
Chapter 5
Developing a vision for a recovery model of service

“The Health Strategy speaks of empowerment as being part of its vision. The essential ingredient of empowerment is equality. With equality comes the possibility of partnership and participation and a move away from a deficit view of mental illness to a focus on wellness and recovery. In such a partnership people become active participants in their own good health”

(Schizophrenia Ireland/Irish Psychiatric Association, 2003)

With the establishment of the Mental Health Commission, the advent of the Expert Group on Mental Health Policy and the increased visibility of mental health service user groups, a vigorous debate has begun within Irish mental health which questions the nature of the services we offer to people with mental health difficulties. There is, as we have seen, an awareness in many quarters of our mental health services of the need to move towards a partnership model of service delivery and towards a more participative model of service development. However although there has been, in some areas of the country, a willingness by the mental health services to fund or co-fund innovative projects, mainly in the occupational, training and social support areas and some service developments within mental health are tending to be more “people-centred”, overall our statutory mental health services continue to operate largely in a traditional hierarchical way with health professionals firmly in charge of the planning, organisation and dispensing of services. We have not, as a rule, consulted service users in the planning of services. Resources within our services are still, by and large, allocated and services structured in ways that healthcare professionals determine to be most advantageous to clients without the direct input of those clients who will use the service. Consultations undertaken in recent years have shown that our service users do have definite views about what constitutes a good mental health service and would like to see major changes in the way services are organised and delivered (Pathways Report (2002), “What we Heard”(2004), Quality in Mental Health -Your Views (2005)). We have not yet faced the challenge of incorporating these views into service development.

The recovery model emphasises the centrality of the personal experience of the individual and importance of mobilising the person’s own resources as part of treatment. It emphasises the development of individualised self-management plans rather than compliance with a standard treatment regime. In our mental health services we have not yet incorporated self-management programmes as central elements of treatment plans.

“Nearly half (49%) of participants were not involved in planning their discharge from the inpatient psychiatric unit, while 94% of those who were involved reported that this was beneficial”.

Pathways Report 2002
The recovery model places a central importance on peer support, on formal and informal support from those who have had similar experiences and can offer companionship and support on the journey towards recovery. Within our mental health services self-help organisations and resources are generally seen as optional extras to the central roles of medication and professional advice. We have tended to underestimate the importance of having one’s experience validated and valued and of being able to access the support of others who have had similar experiences.

“Looking back now I realise that the greatest way in which the group helped was their acceptance of me as I was, unconditionally, they also understood what I was going through. The affirmation I received helped me to build my self-esteem”

Soul Survivors 2003

The recovery model focuses on the uniqueness of each person and their experience rather than on similarity of clinical presentation. In our services we have tended to sideline the individual human experience in favour of clinical diagnosis and clinical management rather than being able to hold both perspectives simultaneously as important.

“Therapists must give people enough time to express themselves. They must have a deep understanding of what it means to be human … They must respect and care for their clients as equal human beings, not as inferior or less knowledgeable people than the therapists themselves.”

Lynch (2001)

In terms of our capacity to deliver a recovery oriented service, a more pervasive difficulty, perhaps, exists in the overall culture of our mental health services, in the norm of distancing ourselves from service users rather than acknowledging a common humanity, in the tendency towards maintaining a stance of authority rather than putting our skills and knowledge at the disposal of the service user, in the culture of seeking compliance rather than concordance, of failing to promote self-management rather than dependence and often failing to promote optimism.

“I dream about a service which has got clear exits which show the way out of the system back into the real world”

(Service User in Pathways Report, 2002)
Core Elements of a Recovery-based Mental Health Service

Developing a recovery based model of service would involve very significant change in key areas of our present services

Training in recovery principles: The adoption of a recovery model primarily represents a radical change in thinking about the process of recovery from mental ill health and about the role of mental health professionals in facilitating recovery. Training in recovery principles would need to be available for all staff and be built into induction programmes and professional training programmes for new health professionals. Contact with mental health service users who have recovered would be part of the training of all mental health professionals.

Individualised self-management plans: Individualised treatment programmes, incorporating self management plans, developed in collaboration with the individual service user and his or her support persons would replace standard treatment programmes. Health professionals would seek agreement in respect of treatment programmes in a respectful dialogue with their clients rather than operate on the expectation of patient compliance with expert advice. The Quality in Mental Health - Your Views report (MHC 2005) advocates “respectful, empathetic relationships” and “an empowering approach” to service delivery. Services would develop protocols which ensure that a collaborative approach is facilitated.

Optimism about recovery: The recovery perspective fosters optimism about the possibility of recovery from mental illness based on sound research evidence. All mental health staff would be aware of the findings of outcome studies for serious mental illness and be aware of their important role in fostering hope in service users. Personal self-management plans would identify a person’s strengths as well as vulnerabilities and would work with these strengths as part of the process of recovery.

Peer support and use of community resources are integral parts of recovery plans: The recovery model recognises that help for persons experiencing mental ill-health may involve a range of mental health disciplines but also involves the use of peer supports, formal and informal, and local community resources. Services would identify the peer supports and resources in the local community available to their service users and incorporate the use of these resources as important aspects of individual treatment plans.
Health professionals would work to reduce clinical distance: Mental health professionals would be able to establish professional relationships with service users based on a respectful collaboration which acknowledges the expertise which the professional may be able to offer, the unique knowledge the individual has about his or her own experience and their common experience as human beings. Professionals would be highly qualified and skilled but would also be able to see themselves as human beings who will experience trauma at different points in their own lives and who can imagine what it is like to be ill.

Service developments would incorporate the expert knowledge of service users: Mental health service users, as important stakeholders, would be involved at all levels in the planning of all service developments. Management structures would be widened to incorporate the involvement of service users. At present our mental health system tends to disregard the valuable knowledge of those who have found a pathway to recovery as somewhat insignificant.

Equality of access to mainstream housing, education, health and social services: Services would work to ensure that service users have proper access to mainstream services in all respects and would develop mechanisms for facilitating this access rather than developing separate and potentially ghettoising services for users of mental health services.

An increased emphasis on psychosocial research and research using qualitative and action research paradigms which can capture more of the complex multilevel data which comprises the experience of mental illness and recovery: Traditional scientific research methods tend to be reductionist in terms of the data which can be gathered and the outcome variables are measured, and would need to be balanced by research which can address a wider range of human variables.

The recovery model forces a rethink of some fundamental aspects of our present services and indeed of the whole structure of our interactions with those who consult our mental health services. The Mental Health Commission hopes that this discussion paper will serve to stimulate constructive debate about the recovery-based model of mental health services and its potential application within our services.
Facilitating Discussion and Submissions

This discussion paper is being circulated to encourage and inform debate on the recovery model in mental health services.

We hope that all the stakeholders will have an opportunity to consider the issues raised in this paper and will then share these views with the Mental Health Commission. Following an analysis of the submissions received, the Commission will issue a policy paper on the recovery model in the Irish mental health services.

It would help in reviewing the comments we received if your response would focus on the following questions:-

- Do you think the recovery model is relevant to the Irish mental health services?
- Do you know of any area within the mental health services where the recovery model is used?
- In your view what are the barriers to promoting the recovery model within the Irish mental health services?
- In your view what are the factors that will facilitate the recovery model within the Irish mental health services?
- What, in your view, is the single factor that would promote the recovery approach in our mental health services?
- What is your view of user-self-management programmes in mental health as have been developed for physical illnesses?
- Any other comments on the discussion paper.
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Appendices
Appendix 1
Healthcare Model WONCA 2002

Healthcare model from World Organisation of Family Doctors

(WONCA 2002)

Appendix 1: Boundaries and choices. Informed choice is very desirable when the risks and benefits of health care are being considered. All health workers can play an important part by encouraging self-reliance, positive health practices and less dependence on unnecessary medication or certification. However, much research needs to be done on how to present fairly the risks and benefits of interventions.

The boundaries between self-care, primary care (GP and Community Care), secondary care (Psychiatrist and multidisciplinary psychiatric team) and tertiary care (Special units within psychiatry) are changing all the time in response to public expectations and these are influenced by many factors in addition to the doctor-patient relationship. This is why an understanding of help-seeking behaviour is of basic importance to those who meet the public in the front lines of health care (Stott, 1982, Philips, 1986).

Mental Health Organisation - Extract from Recovery Model

## MENTAL HEALTH RECOVERY PROCESS CLINICAL CARE

<table>
<thead>
<tr>
<th>CONSUMER'S STATUS</th>
<th>DEPENDENT/ UNAWARE</th>
<th>DEPENDENT/ AWARE</th>
<th>INDEPENDENT/ AWARE</th>
<th>INTERDEPENDENT/ AWARE</th>
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<tbody>
<tr>
<td></td>
<td><em>Cannot identify personal needs;</em> <em>Uninformed of resource opportunities;</em> <em>May be angry, anxious, distrustful, and unmotivated;</em> <em>May not accept diagnosis;</em> <em>Symptoms, treatment, and stigma may interfere with motivation;</em> <em>May experience shame &amp; stigma concerning illness;</em> <em>May lack experience in developing trusting relationships.</em></td>
<td><em>Depends on professional care;</em> <em>Aware of illness;</em> <em>Aware of services &amp; choices available within system;</em> <em>May not feel empowered to make choices;</em> <em>May not be interested or desire to make appropriate choices;</em> <em>May begin to set basic recovery goals.</em></td>
<td><em>Takes responsibility for managing his/her life and illness;</em> <em>Aware of choices of services, treatment, and other resources;</em> <em>Makes choices independently;</em> <em>Reasonably self confident and values personal worth;</em> <em>Chooses level of involvement with family/significant others, peer groups and community activities;</em> <em>Works toward achieving recovery goals previously developed.</em></td>
<td><em>Accepts responsibility &amp; involves him/herself in community;</em> <em>Views service providers &amp; personal support system as partners and peers;</em> <em>Works collaboratively with service providers &amp; personal support system to make choices;</em> <em>Feels he/she has an opportunity to contribute to others and to society;</em> <em>May move out of public system for attainment of employment and private benefits.</em></td>
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<tr>
<td></td>
<td><strong>CLINICIANS' ROLES</strong></td>
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<td></td>
<td><em>Demonstrates hope and achievement when interacting with consumer;</em> <em>Promotes acceptance as first step to recovery;</em> <em>Explains illness, symptoms, courses of treatment and hope for the future and begins to reach consumer about the use and benefits of a personal Relapse Prevention Plan and Advance Directives;</em> <em>Informs consumer of benefits of active treatment;</em> <em>Engages family/significant others and refers them to available community supports and education.</em></td>
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<tr>
<td></td>
<td><em>Ensures consumer and family/significant others are educated about the choices/resources available to them;</em> <em>Provides activities that will increase consumer's readiness to make choices in selecting life roles, environment, and goals;</em> <em>Educates consumer about mental illness &amp; recovery;</em> <em>Continues hope instilling strategies;</em> <em>Involves consumer in designing his/her Recovery Management Plan including medication and side effects, Relapse Prevention Plan and Advance Directives.</em></td>
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<tr>
<td></td>
<td><em>Works with consumer to define and achieve preferred life roles &amp; goals;</em> <em>Continues instilling hope strategies;</em> <em>Encourages input from family/significant others as appropriate;</em> <em>Encourages development of individualized coping strategies to deal with persistent symptoms;</em> <em>Continues to support consumers with medication management;</em> <em>Encourages consumer to use personal Recovery Management Plan, Relapse Prevention Plan and Advance Directives as necessary.</em></td>
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<td></td>
<td><em>Works with consumer &amp; consumer chosen support system to enhance/support chosen life roles;</em> <em>Provides information and contracts to consumer to help locate other community resources &amp; supports;</em> <em>Provides consumer ongoing continued support;</em> <em>Supports consumer in his/her interdependent role in community and society.</em></td>
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</table>
## MENTAL HEALTH RECOVERY PROCESS EMERGING BEST PRACTICE CLINICAL CARE

<table>
<thead>
<tr>
<th>DEPENDENT/UNAWARE</th>
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<th>INTERDEPENDENT/AWARE</th>
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<tbody>
<tr>
<td>Makes available family and consumer peer support, consumer enrichment and engagement activities;</td>
<td>Makes available educational opportunities for consumers and their families/significant others that focus on mental illness, recovery process, and strategies that facilitate recovery;</td>
<td>Community resources address treatment, life goals, chosen roles, goals, &amp; social needs;</td>
<td>Makes available for consumer collaborative support as needed to remain in chosen life role;</td>
</tr>
<tr>
<td>Makes available, especially to families and consumers, information and education concerning mental illness.</td>
<td>Provides support and information to overcome stigma and enhance community inclusion (e.g., via churches, community organisations);</td>
<td>Promotes &amp; supports anti-stigma campaigns;</td>
<td>Continues to seek respect &amp; value consumer &amp; family/significant other involvement in community activities &amp; organisations;</td>
</tr>
<tr>
<td><strong>COMMUNITY SUPPORTS ROLES</strong></td>
<td></td>
<td>Actively seeks and supports consumer &amp; family/significant other involvement in community mental health programs.</td>
<td>Continues to support consumer &amp; family/significant others.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>CONSUMER’S BEST PRACTICES</th>
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</thead>
<tbody>
<tr>
<td>Identifies information about mental illness, recovery process, stigma, self-esteem, and building self confidence;</td>
<td>Gains awareness of cyclical or episodic nature of illness &amp; that recovery is not a linear process;</td>
<td>Seeks out information from providers &amp; other resources;</td>
<td>Reviews personal Recovery Management Plan to update &amp; note accomplishments;</td>
</tr>
<tr>
<td>Gains awareness of illness through symptom reduction &amp; education;</td>
<td>Begins to set recovery goals;</td>
<td>Participates in structured activities;</td>
<td>Reviews journal to determine progress;</td>
</tr>
<tr>
<td>Develops self trust by living through traumatic events with support (e.g. hospitalisation, family problems, incarceration);</td>
<td>Uses available resources;</td>
<td>Monitors illness &amp; medications &amp; reports needs to clinician/physician;</td>
<td>Takes an active part in peer &amp; advocacy efforts;</td>
</tr>
<tr>
<td>Begins to develop trusting relationships with clinician and others.</td>
<td>Accepts illness &amp; treatment;</td>
<td>Develops &amp; achieves recovery goals;</td>
<td>Works with other consumers to achieve personal life goals;</td>
</tr>
<tr>
<td><strong>CONSUMER’S BEST PRACTICES</strong></td>
<td>Participates in peer support activities;</td>
<td>Develops &amp; uses own personal coping skills for dealing with residual of recurring symptoms &amp; personal support system;</td>
<td>Uses mental health services on an “as necessary” basis;</td>
</tr>
<tr>
<td></td>
<td>Reshapes identity;</td>
<td>May keep journal that focuses on feelings; expectations, &amp; life roles;</td>
<td>May choose to use private system based upon employment benefits received;</td>
</tr>
<tr>
<td></td>
<td>Begins to make more appropriate choices/decisions;</td>
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<tr>
<td></td>
<td>Participates in prescribed treatment;</td>
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</tr>
<tr>
<td></td>
<td>Keeps appointments with doctors &amp; therapists;</td>
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<td></td>
<td>Attends &amp; participates in self help group meetings</td>
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<tr>
<td></td>
<td>Seeks alternative treatment (e.g. vitamins/herbs, social interactions instead of groups).</td>
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</table>
## MENTAL HEALTH RECOVERY PROCESS

### PEER SUPPORT & RELATIONSHIPS

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<tr>
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</thead>
<tbody>
<tr>
<td>Builds relationship with consumer by listening, valuing &amp; accepting him/her as a worthwhile person;</td>
<td>May involve consumer in groups designed to target issues related to transitioning back to community, goal setting, and building relapse prevention strategies and Advance Directives;</td>
<td>Assists consumer in connecting with community services based upon his/her needs;</td>
<td>Monitors with consumer Recovery Management Plan;</td>
</tr>
<tr>
<td>Continues using hope instilling strategies;</td>
<td>Refers family significant others to psycho-education classes;</td>
<td>Works with consumer to review &amp; monitor status of his/her goals;</td>
<td>Provides support and assistance in maintaining recovery;</td>
</tr>
<tr>
<td>Develops collaboratively with consumer, family/other, and physicians on Recovery Plan;</td>
<td>Provides (as appropriate) printed information on diagnosis &amp; available resources;</td>
<td>Works with consumer to define Recovery Support Plan, Relapse Prevention Plan, and Advance Directives;</td>
<td>Advocates use of community resources;</td>
</tr>
<tr>
<td>Collaborates with consumer in managing illness with proper medication by providing information about medication, strategies for effective management.</td>
<td>Continues to use hope instilling strategies;</td>
<td>Assists consumer in contacting agencies &amp; services that will help him/her achieve life goals &amp; support recovery enhancing activities (i.e., GED, BVR, recovery groups, housing options, volunteer opportunities);</td>
<td>Encourages &amp; supports consumer in becoming more involved in community activities;</td>
</tr>
<tr>
<td>Develops rapport &amp; positive relationships with consumer’s family/significant others;</td>
<td>Helps consumer learn coping skills;</td>
<td>Refers to Social Security to learn about how to use work incentives;</td>
<td>Keeps consumer and family current about new medications.</td>
</tr>
<tr>
<td>Assists consumer in setting &amp; reaching goals; thus increasing personal control &amp; self-esteem;</td>
<td>Keeps current on research &amp; treatment to assist consumer in gaining mastery over symptoms;</td>
<td>Supports &amp; assists consumer in developing personal coping skills;</td>
<td></td>
</tr>
<tr>
<td>Links consumer to appropriate services, benefits, and entitlements;</td>
<td>Assists consumer in developing goals that are shaped by external ideals;</td>
<td>Assists consumer in developing a personal emergency support system including peers, friends, significant others.</td>
<td></td>
</tr>
<tr>
<td>Connects consumer with successful role models.</td>
<td>Develops with consumer his/her Relapse Prevention Plan and Advance Directives.</td>
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</tbody>
</table>

### CLINICIAN BEST PRACTICES

- Conducts depression screenings, stress tests, etc., at Health Fairs;
- Provides educational products, programs, opportunities that meet the needs of the consumer;
- Makes psycho education & peer support groups available to families/significant others;
- Provides & supports Drop-in Centers.

### COMMUNITY SUPPORTS BEST PRACTICES

- Continues providing psycho-education;
- Designs inclusive support activities for consumer & family/significant others;
- Continues to make available peer support groups for consumers and their families/significant others;
- Provides education that focuses on overcoming stigma.

- Expands community support;
- Increases opportunities for consumer to become involved in community;
- Continues anti-stigma public education.
### MENTAL HEALTH RECOVERY PROCESS EMERGING BEST PRACTICES

#### PEER SUPPORT & RELATIONSHIPS

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<tbody>
<tr>
<td></td>
<td>May have lost contact with peers;</td>
<td>Defines his/her unique needs;</td>
<td>Gives support to others;</td>
<td>Cultivates reciprocal relationships;</td>
</tr>
<tr>
<td></td>
<td>Lacks self-esteem and sense of self;</td>
<td>Regains sense of hope &amp; becomes aware of self esteem issues;</td>
<td>Uses peer support as component of personal support network;</td>
<td>Participates in community;</td>
</tr>
<tr>
<td></td>
<td>May have limited knowledge of supportive resources and medical management;</td>
<td>Understands importance of maintaining balance &amp; wellness in life;</td>
<td>Obtains and uses resources, supports, and services;</td>
<td>Willing and ready to give back to community;</td>
</tr>
<tr>
<td></td>
<td>May experience spiritual and/or cultural conflict;</td>
<td>Views self as “subject”;</td>
<td>Begins to use Relapse Prevention Plan;</td>
<td>Serves as role model for other consumers;</td>
</tr>
<tr>
<td></td>
<td>Views self as object;</td>
<td>Begins using self-reliant model;</td>
<td>Recognises and develops plans to monitor symptoms;</td>
<td>Advocates for self and others;</td>
</tr>
<tr>
<td></td>
<td>May feel hopeless and helpless;</td>
<td>Develops life skills;</td>
<td>Begins to value self as a unique individual with strengths and achievable goals.</td>
<td>Manages stress;</td>
</tr>
<tr>
<td></td>
<td>May be withdrawn and avoids contact with others.</td>
<td>Participates in self help/peer support groups;</td>
<td></td>
<td>Shares coping techniques with other consumers &amp; clinicians;</td>
</tr>
</tbody>
</table>

#### CLINICIANS' ROLES

<p>|                    | Makes consumer aware he/she is not alone; | Establishes relationship with consumer that is reciprocal; | Utilizes volunteers to share recovery information &amp; experiences; | Recognises individual versus consumer; |
|                    | Offers hope &amp; friendship; | Assists consumer with identifying needs and linking to peers; | Involves consumer in groups with Peer Supporters that participate regularly in some type of recreational/social activity; | Helps consumer identify ways to give back to community; |
|                    | Encourages consumer to remain active; | Facilitates group/peer interactions; | Teaches consumer about Mental Health Directives &amp; process involved; | Provides consumer with access to group advocacy training; |
|                    | Identifies support and provides access to peer support; | Assists consumer in understanding &amp; managing relationship issues; | Evaluates effectiveness of support provided by peers; | Encourages consumer participation in program evaluation &amp; quality assurance activities; |
|                    | Helps consumer develop reciprocal relationships; | Provides access to personal advocacy; | Reviews with consumer his/her Relapse Prevention Plan; | Collaborates with consumer in developing, finding, and using self-help alternatives; |
|                    | Assists consumer in recognising strengths and valuing peer support experiences; | Offers opportunities to consumer to venture into community. | Monitors consumer’s ability to maintain Relapse Prevention Plan; | Collaborates with consumer to conduct research &amp; publish about the benefits of peer support; |
|                    | Fosters advocacy and assists consumer in taking control of his/her illness; | | Supports consumer in community activities. | Expands peer group to include clinicians &amp; providers. |
|                    | Provides consumer with information about how to obtain access to services; | | | |</p>
<table>
<thead>
<tr>
<th>COMMUNITY SUPPORT ROLES</th>
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<tbody>
<tr>
<td></td>
<td>Makes peer support groups available and accessible;</td>
<td>Provides educational opportunities to consumer that focus on available programs &amp; services;</td>
<td>Recruit individuals interested in becoming Peer Supporters;</td>
<td>Involves consumer on mental health boards;</td>
</tr>
<tr>
<td></td>
<td>Involves peer support groups in treatment sessions when appropriate;</td>
<td>Makes accessible &amp; available Drop in Centers and consumer peer support groups.</td>
<td>Involve consumer in social and recreational activities;</td>
<td>Makes community support groups accessible and available.</td>
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<td>Provides personal assistance;</td>
<td></td>
<td>Conduct meetings of Peer Supporters.</td>
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<td>Offers hope through peer supporters making non-threatening visits;</td>
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<td></td>
<td>Peer Support Group participates in community activities (i.e., food drives, community clean up).</td>
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<tr>
<td>CONSUMER’S BEST PRACTICES</td>
<td>Becomes willing to engage in interactions with others;</td>
<td>Identifies self esteem issues, short-term goals &amp; strategies to overcome fear of self disclosure;</td>
<td>Gives support to others;</td>
<td>Participates in advocacy activities;</td>
</tr>
<tr>
<td></td>
<td>Listens to information given on mental illness &amp; healthy support systems.</td>
<td>Becomes interested in returning to community &amp; identifying services/resources available within the community;</td>
<td>Obtains &amp; uses resources, supports, and services;</td>
<td>Follows his/her Relapse Prevention Plan;</td>
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<td></td>
<td>Develops or maintains spiritual, social, and cultural connections;</td>
<td>Accepts mental illness;</td>
<td>Uses self determined Relapse Prevention Plan;</td>
<td>Takes responsibility for own wellness;</td>
</tr>
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<td></td>
<td>Begins to see the possibilities.</td>
<td>Learns about personal symptoms of illness;</td>
<td>Uses self developed plans to monitor symptoms;</td>
<td>Maintains purpose in daily routine through participation in meaningful activities (e.g. paid work, therapeutic groups, peer support groups, and volunteer work) and gives back to community;</td>
</tr>
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<td></td>
<td>Begins to build Relapse Prevention Plan;</td>
<td>Active in Peer Support Group;</td>
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<td></td>
<td></td>
<td>Develops meaningful, supportive personal relationships.</td>
<td>Peer Support is a valued component of personal support network;</td>
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<td>Values self.</td>
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<td></td>
<td>Values self and peers.</td>
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<td>DEPENDENT/UNAWARE</td>
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</tr>
<tr>
<td>Involves consumer in groups (e.g., Peer Support, Self Esteem) designed to stimulate appropriate interpersonal interaction, facilitate an open dialogue about stabilizing &amp; maintaining relationships and intimacy; provide/promote opportunities to practice using social skills, share information about systems &amp; medical management; promote awareness of transitioning into community;</td>
<td>Utilizes team tasks (e.g., recreational, psycho-social groups) to establish sense of teamwork;</td>
<td>Uses volunteers to share information &amp; experiences of recovery; Involves consumer in groups with Peer Supporters that participate regularly in some type of recreational/social activity;</td>
<td>Is available to support and assist in refining consumer’s peer support choices.</td>
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</tr>
<tr>
<td>Involves consumer in 1-1 sessions for purpose of maintaining rapport and encouraging interactions with others;</td>
<td>Involves consumer in groups for purposes of discussing relationship issues, learning how to manage them; identifying personal hopes &amp; achievements; learning about personal advocacy, and relapse prevention and &amp; Advance Directives;</td>
<td>May involve family members/significant others;</td>
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</tr>
<tr>
<td>Refers to peer support &amp; other interest groups (i.e., spiritual, cultural &amp; recreational);</td>
<td>Assures peer supporters accompany consumer on community trips to various support groups;</td>
<td>Assists consumer in understanding that peer relationships are fluid and must be nurtured.</td>
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</tr>
<tr>
<td>Makes hospital visits &amp; provides literature and information on peer support system; Provides hope &amp; reassurance for recovery to consumer using personal disclosure; Develops rapport with consumer; With clinician’s guidance, begins to engage consumer in non-threatening social tasks (i.e., getting cup of coffee, light conversations);</td>
<td>Provides resource information about community programs &amp; services; Accompanies consumer on community trips to explore support groups; Continues to offer reassurance &amp; hope in recovery process; Encourages consumer to accept &amp; gain increased insight into mental illness; Accompanies consumer to substance abuse support groups in community when appropriate.</td>
<td>Conducts meetings at hospitals; Recruits consumers interested in becoming peer supporters; Involves consumer regularly in some type of social/recreational activity.</td>
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<td></td>
<td>Involves consumer in peer support services; Conducts workshops &amp; in-services designed to increase consumer’s awareness about mental illness; Provides social activities and retreats; Involves consumer in planning community activities.</td>
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</tbody>
</table>