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Exploring the Concept of Recovery in Irish Mental Health Services: A Case Study of Perspectives within an Inter-Professional Team

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Abstract

The concept of recovery has been well documented in the Irish state’s policies on mental health. More widely, the notion has been contested and embroiled in a number of definitional debates. Given the formative nature of this unfolding discourse, this research explored the meaning of recovery from the perspectives of one inter-professional team delivering mental health services to vulnerable individuals within an Irish community setting. The researchers sought to analyse whether the disciplines of medicine, psychology, nursing and social work could work together purposively to promote the biopsychosocial approach to recovery-oriented practice. This vein of inquiry was salient as an array of literature suggested that the traditional biomedical model continued to undermine this approach. The research adopted a case study design and used semi-structured interviews to collect the data. The findings highlighted that the notion of recovery was shared broadly but also embraced diverse inflexions across the various disciplinary leanings. This plurality of meaning encouraged positive examples of working together and promoted a holistic understanding of the service user’s needs, with no specific discipline colonising the professional or therapeutic agenda. These findings generate insights into how recovery can be better understood and progressed within Irish mental health policy and service development.

Keywords

Mental health, inter-professional, recovery.

Introduction

The development of mental health policy and practice in Ireland has witnessed major changes over the last sixty years. Notably, there has been a directive (Department of Health and Children, 2006) to move away from institutionalisation towards community based-interventions - providing an opportunity for people to live more fulfilling and autonomous lives (Pilgrim, 2008). Concomitant with this change, the concept of recovery first entered the realm of mental health discourse in the 1980s. It emphasized the importance of building resilience, positive identity and self-esteem in people experiencing mental health challenges: moving beyond a more attenuated focus on symptomatology and the medicalisation of mental illness. Driven largely by the mental health survivor movement (Davidson et al., 2005), recovery later became central to mental health discourse and policy worldwide by the early 2000s (Barker & Barker, 2011; Davidson et al., 2005; Pilgrim, 2008).

In 2006, the seminal policy document, A Vision for Change, was published in Ireland. It identified recovery as a primary, preferred approach undergirding mental health services (Higgins & McGowan, 2014). The document was welcomed positively, but did not include clear guidelines on how to implement the notion (Higgins & McGowan, 2014). Thus, the
transition from recovery-oriented policy to practice has been problematic (Gaffey et al., 2016; Higgins & McGowan, 2014; Walsh et al., 2008).

This state of affairs has persisted even though recovery remains a fundamental, determinative term within the contemporary, western literature on mental health. Yet, the concept has been interpreted in multifarious ways with commentators (for example, Pilgrim, 2008) drawing attention to its often vague, slippery and disputed nature. Moreover, there has been limited research carried out on professional perspectives on the topic, both within an Irish context and also elsewhere (Higgins & McGowan, 2014). Given this lacuna, this research explored the meaning attached to recovery from the perspectives of a cohort of professionals implementing the approach within an Irish mental health setting. Below, we firstly explicate the meaning of recovery and how it emerged from a biopsychosocial orientation. We then describe the nature of the study and consider its findings.

The Concept of Recovery

Prior to the 1980s, the concept of recovery did not feature in policies and discussions surrounding service reform (Pilgrim, 2008). At the end of the 20th century, it has emerged as central notion within mental health discourse (Barker & Barker, 2011). In 1988, Deegan was one of the first authors to explore its ethos and connotations. Taking her own experience of mental ill-health, she viewed recovery as a process of moving beyond constricting symptomology towards a new sense of self (Stacey & Stickley, 2012). Other academics supported and built on Deegan’s ideas (Anthony, 1993; Barker, 2003; Fisher, 2008). For instance, according to Stacey and Stickley (2012, p.534), recovery was a ‘subjectively determined’ process of existential growth.

For Higgins and McGowan, by way of contrast, recovery was conceptualized ‘as a movement, a philosophy, a set of values or principles, a paradigm and a policy’ (2014, p.63). Based on this epithet, they categorized recovery under three headings, namely: (a) clinical recovery – from debilitating medical symptoms; (b) functional recovery – from a deficit in social and occupational skills; and (c) personal recovery - from a negative view about self towards a position of enhanced self-efficacy. This more multi-faceted typology gained the assent of a number of commentators (Higgins, 2008; Ramon et al., 2009).

Chester et al. (2016), in a similar configuration, depicted recovery under the headings of: (a) clinical (b) service-defined and (c) personalised recovery. The definitions of clinical and personal recovery were the same as those outlined by Higgins and McGowan. However, service-defined recovery referred to organizational visions and policies for various types of mental health service. In most cases, clinical recovery determined the service-defined response by emphasizing goals such as stabilization and return to a normal (sic) level of functioning.

In a congruent vein, Pilgrim has written extensively about the concept of recovery, most notably in his publication, Recovery and Mental Health: A Critical Sociological Account (2013). He defined recovery as a polyvalent concept (p.39), meaning it ‘has many meanings and no single and stable definition has been produced’ (p.64). Overall, Pilgrim argued that due to this confusion and vagueness surrounding the concept, it was a ‘working misunderstanding’ (p. 35-64).

To recapitulate, it is clear that the concept of recovery is open to interpretation and (perhaps) contested appellation. Such definitional attempts at these show how the concept has evolved
reflecting a range of meanings culminating in a level of ambiguity, especially when attempting to operationalize it within practice and service delivery (Davidson et al., 2005). However, a unifying message is that recovery can take place with or without psychotropic medication. Moreover, it involves the service user not only managing their illness, but also pursing ‘normality’ in their life through work, education and living independently. The main challenge within the recovery discourse is how services can be orientated towards these aspirations. This remains an obdurate challenge because it involves ‘a shift in attitudes, culture and power within a rigid system which historically has been hierarchical in nature’ (Gaffey et al., 2016, p.2). In the next section we highlight, in more detail, the tenets of a central, paradigmatic debate in mental health service provision between the biomedical and recovery-informed perspectives.

**The Conflicting Paradigms: Biomedical and Recovery-Informed**

Essentially, the biomedical paradigm postulates that mental ill-health should be viewed as an organically driven, disease process involving the brain and, invariably, imbalanced chemical processes leading to disorders of mood and thought (Engel, 1977). More specifically, the contention is that many mental disorders are triggered by an amalgam of interconnected, neuro-biological transmitter irregularities, genetic variances, chemical disturbances and faults in brain architecture. Pharmacological and somatic interventions are then, unsurprisingly, adopted as the main forms of clinical treatment giving rise to a disease-based model of drug action. These essential premises, though, coming as they do from a burgeoning, neuro-scientific, pharmacological discourse, and its influence on bio-psychiatry, have not been sufficiently evidenced through the identification of robust biomarkers nor a proven link between chemical imbalance and mood disorder (Deacon, 2013). But more than that, by succumbing principally to biological reductionism, this stance obfuscates the wider psycho-social determinants of mental illness including the effects of poverty and social isolation.

The recovery paradigm, by way of contrast, conceptualises mental illness in a fundamentally different way by emphasising the importance of the latter factors. This is not to say that medication is peripheral in importance, but rather that recovery can be achieved in multifarious ways (Gehart, 2012). Tellingly, in 1994, Elizabeth Gowdy spoke about the dilemma facing social workers caught between technical rationality and other ways of problem-solving. Technical rationality along with its off-shoot, scientific inquiry, studied the person objectively to reach technical solutions. It had become the dominant *modus operandi* for resolving pressing issues. Yet, for Gowdy, the profession was compelled to move beyond this paternalistic stance to one that privileged the service user as the expert in her life (1994). The dilemma she described in social work (over twenty years ago), now appears to be taking place in mental health practice in Ireland since the implementation of *A Vision for Change*. Conspicuously, up until 2006, psychiatrists and nurses in Ireland mostly adopted a biomedical approach to practice, underpinned by a technical rationality perspective. The literature highlighted that it has been a struggle for these professionals to adopt a multi-faceted, person-centred approach to practice (Brosnan & Sapouna, 2015).

The official acceptance of policy documents such as *The Commission of Inquiry on Mental Illness* (1966), *Planning for the Future* (1984) and, in particular, *a Vision for Change* (2006), have demonstrated a shift in how recovery should be viewed and approached in practice (Higgins & McGowan, 2014; Walsh et al., 2008). It involves ‘making a shift in organisational and cultural practice’, placing the service user in the expert role in their lives and their experience of mental illness (Brosnan & Sapouna, 2015, p.167). One of the main themes enunciated in the literature is the conflict between differing epistemological positions.
undergirding the recovery and biomedical paradigms: the former elevating a humanistic, person-centred orientation - the latter, a positivist stance (Brosnan & Sapouna, 2015).

This shift from a biomedical to a biopsychosocial approach has been continuing for over twenty years (Bowell-Carrio et al., 2004; Chester et al., 2016; Engel, 1977; Leff & Vaughan, 1981). The required evolution in practice has been problematic with a lack of transparency between what is written in reports and policies in various countries and what is taking place in practice (Schwartz et al., 2013). In Ireland, the implementation of a recovery-orientated approach has been slow and has lacked consistency (Brosnan & Sapouna, 2015).

Findings published in 2008, identified that health professionals who were unsure of their practice, tended to resort to what they knew best, which was a biomedical approach (McAllister & Moyle, 2008). Similarly, in Ireland, a study carried out in 2014 explored the barriers which prevented the principles associated with recovery being implemented (Keogh et al., 2014). The main obstacle according to the participants was challenging the dominance of the biomedical approach in Irish mental health services.

Recovery policies and research documents outline how such obstacles can be overcome. However, the shift from biopsychiatry to recovery in practice involves a lot more than ‘a few deft strokes of a pen’ (Walsh et al., 2008, p.251). Organisations such as the Mental Health Commission and Mental Health Reform have emphasised the importance of leadership at national level combined with a variety of ‘cultural and structural changes within organisations to support the development of recovery-orientated services’ (Higgins & McGowan, 2014, p.69). Understanding how this shift is enacted in day-to-day, inter-professional practice, is the aim of this study.

**Method**

The research design was shaped by a number of objectives, namely to:

- Explore the meaning of recovery in one case study involving an Irish, mental health, inter-professional team;
- Evaluate the extent to which a recovery approach informed practice in this setting; and
- Discover if there were any influential factors affecting the delivery of recovery practices.

The researchers adopted a phenomenological, interpretive perspective as the methodological basis of the inquiry. This perspective centres on the elicitation of meanings, attitudes and perceptions. Put another way, phenomenology is concerned with people describing social phenomena freely without restrictions. In this context, this perspective is fundamental because, to explore the concept of recovery and the various themes surrounding its present day meaning, a description of its development is required (Allan & Eatough, 2016; Barnacle, 2001). Furthermore, according to Bryman (2008, p. 694), an interpretivist perspective “requires the social scientist to grasp the subjective meaning of social action”.

Building on these precepts, the selection of a case study design seemed apposite. Case study designs are used in many situations where the research intends to collect knowledge concerning individuals, groups, organisations and other social phenomena (Yin, 2003). Therefore, it was chosen because it collects detailed and intensive analysis of one particular community, theme or organisation (Bryman, 2008). Yin (2003) states that a case study design enables the
researcher to investigate the holistic and meaningful characteristics of real life events including organisational processes and how theoretical aspirations are transferred into professional transactions and interventions. The nature of the research objectives, consequently, provided the justification for the use of a case study design.

Semi-structured interviews were chosen as the approach to data collection. They are congruent with exploratory, qualitative designs (Brinkmann, 2013; Bryman, 2008) and a phenomenological, interpretive orientation (Alston & Bowles, 2003). Semi-structured interviews can include open questions, prompts and probes which allow the researchers to engage the participants in describing and interpreting the meaning of social phenomena (Alston & Bowles, 2003; Saldana, 2011). They are well suited to case study designs because of the focus being directly on the topic under exploration (Yin, 2003). Focus groups were considered as a possible alternative to semi-structured interviews. However, following consultation with the inter-professional team, the researchers became aware that each professional’s time schedule varied. In short, there was not one specific period when they would all be available to meet collectively.

Seven semi-structured interviews were carried out with members of the team. The flexibility afforded by this approach to data collection allowed the researchers to gather a wide range of information about the concept of recovery. Although applied adaptably, an interview guide was developed to keep the focus on the research topic (Bryman, 2008; Maykut & Morehouse, 2005). There were four main themes covered during the interview, namely the participants’ perceptions of: (i) the biomedical and recovery-informed paradigms; (ii) how recovery was practiced within a multi-disciplinary setting; (iii) how the concept of recovery had developed within shifts in Irish Mental Health policy and services; and (iv) whether risk in mental health practice had any bearing on recovery-oriented practice.

The researchers focused on one inter-professional team employed by the Health Services Executive in a rural part of Southern Ireland. A prior consultation with a gatekeeper (or access facilitator) appointed by the agency had identified this team due to their capacity to meaningfully address the research questions posed by the study. Thus, this cohort was chosen purposively in line with non-probability sampling. Non-probability sampling was the most appropriate method because it is used predominately for exploratory studies such as the one described here.

There were no criteria regarding the characteristics that the participants needed to exhibit other than that they were all members of the same inter-professional team, professionally qualified in their own discipline, and had recent experience implementing a recovery-oriented approach. The team included a Consultant Psychiatrist, General Practitioner, Clinical Psychologist, Occupational Therapist, Psychiatric Social Worker and two Community Mental Health Nurses. All these characteristics are shown below:
Table 1 – Characteristics of sample

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Psychiatrist</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>41-50 years old</td>
</tr>
<tr>
<td></td>
<td>21-30 years professional experience</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>41-50 years old</td>
</tr>
<tr>
<td></td>
<td>21-30 years professional experience</td>
</tr>
<tr>
<td>Community Health Nurse 1</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>31-40 years old</td>
</tr>
<tr>
<td></td>
<td>11-20 years professional experience</td>
</tr>
<tr>
<td>Community Health Nurse 2</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>41-50 years old</td>
</tr>
<tr>
<td></td>
<td>21-30 years professional experience</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>31-40 years old</td>
</tr>
<tr>
<td></td>
<td>1-10 years professional experience</td>
</tr>
<tr>
<td>General Practitioner (on</td>
<td>Female</td>
</tr>
<tr>
<td>placement)</td>
<td>31-40 years old</td>
</tr>
<tr>
<td></td>
<td>Less than 1 year professional</td>
</tr>
<tr>
<td></td>
<td>experience in mental health</td>
</tr>
<tr>
<td>Psychiatric Social Worker</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>41-50 years old</td>
</tr>
<tr>
<td></td>
<td>21-30 years professional experience</td>
</tr>
</tbody>
</table>

Table 2 – Characteristics of Researchers

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Stan Houston</td>
<td>Male</td>
<td>50-60</td>
<td>Professor of Social Work</td>
</tr>
<tr>
<td>Calvin Swords</td>
<td>Male</td>
<td>20-30</td>
<td>Master of Social Work Student at the time</td>
</tr>
</tbody>
</table>
The study was undertaken by a master’s student and his research supervisor. They chose to analyse the data thematically following the transcription of the interviews. According to Willig (2013), thematic analysis is one approach that allows the researchers to answer their research questions from a phenomenological, interpretive position. Once the interviews were transcribed, we started the process of thematic analysis by familiarizing ourselves with the transcripts, leading to the identification of a number of codes. These codes described small units of text (Taylor et al., 2016). Following this step, themes were derived inductively from the codes. The themes constituted more abstract categorizations or deeper analytical depictions of meaning within the text. This process was carried out using a number of different coloured highlighters. Importantly, the themes were confirmed after ensuring they were linked visibly to the data. As part of this verification, the researchers were keen to establish internal homogeneity within the elicited themes, noting any discrepant outliers (Willig, 2013).

Trustworthiness

The researchers undertook a rigorous system of cross referencing the codes and themes which they were identifying in the data (Braun & Clarke, 2006; Bryman, 2008; 2012). This supported the trustworthiness of how the data was analysed. Furthermore, the researchers used memory checking with members of the sample regarding the data they had collected (Birt et al., 2016).

Due to the nature of qualitative research, the researchers were continuously aware of how their own subjectivities could potentially impact on the outcomes of the data collected and presented (Berger, 2015; Bryman, 2012; D’Cruz, Gillingham, & Melendez, 2007). In order to maintain a critical reflection of the researchers own biases, reflexivity was a key consideration throughout the research process (Bryman, 2012; Pillow, 2003).

The process of reflection was underpinned by the framework developed by Professor Stan Houston - *Reflective Practice: A Model for Supervision and Practice in Social Work* (2015). This framework was used by the researchers to underpin the journaling and supervision discussions regarding the research design that had been undertaken. These processes supported the researchers in maintaining an awareness of biases, but also to manage expectations regarding the inductive and deductive approach being taken to the data collection and analysis (Berger, 2015; Bryman, 2012; D’Cruz, Gillingham, & Melendez, 2007).

The study received ethical approval from the researchers’ host university and the Health Service Executive’s ethics committee for the area.

Findings

Five themes emerged from the data, namely:

- The meaning of recovery;
- Shifts in approach to practice;
- The inter-professional approach to recovery;
- Risk management as a factor influencing recovery; and
- Service user involvement & responsibility.

*The meaning of recovery*

From the findings, the concept of recovery had a number of meanings attached to it:
it’s not just looking at the medication...engaging in other activities...so many different definitions of recovery...it’s not like there is one definition... (Occupational Therapist)

We would like to help a patient to be at the end of treatment, quote unquote, is very much to be recovered. Now what that means for an individual patient is very different. (General Practitioner)

When talking about recovery, the focus extended beyond the use of medication to consider its existential and humanistic aspects:

That movement from that really acute experience towards feeling better...also I suppose that broader kind of picture about recovery in the area of functioning...those skills of being able to function effectively...deeper level, it’s you know, not always will we be able to say that somebody will never become unwell again, struggle again...To begin to feel, choose as a person how I respond to that...recovery can be transformative. (Clinical Psychologist)

The participants introduced the idea that a patient’s skills could be enhanced to improve their ability to function. Furthermore, recovery was not viewed in an indiscriminate way, but rather as personalised and individualised: someone choosing their recovery pathway to attain fulfilment. Recovery was a process which could therefore be transformative. The professionals described recovery as synonymous with people recuperating to an optimal level of being:

You have a mental illness but despite that you can still live a fulfilling life. (Occupational Therapist)

Recovery is, it is helping a person, to help themselves to become, the best possible that they can be. (General Practitioner)

The participants described the role played by the person in this process:

The idea of somebody being in control of their own life engaging in meaningful activity that is what we do now. (Occupational Therapist)

‘The individual takes responsibility to achieve objectives, facilitated by the services and I think that is what I would like to see what recovery means. (Consultant Psychiatrist)

‘There is a way forward from where we are...you and I will figure it out together, or you’ll figure it out and help you do it. (Psychiatric Social Worker)

The patient or individual plays a central role in all of this with the health and social care professionals providing them with support to assist them on their journey, whatever that may be. The General Practitioner in the study explained this as follows:

Somebody who has a chronic, enduring, psychotic illness may never go back to work...never be able to live entirely independently...managing to live in you know a supportive home, where their medication is supervised, and they have a reasonable amount of autonomy can be huge for them.

Shifts in approach to practice

The participants discussed their views on the closure of hospitals and whether it was a good or bad shift in practice:
It’s maybe important that we don’t lose sight of this, the idea of sanctuary. Emm, the hospital is a place of safety. Em, for people in times of difficulty…we need to be careful with the change in policy. (Clinical Psychologist)

I am in favour of community care and undoubtedly, we had too many beds…speak against, is closing to many beds that there is no beds available for those who really needs it. (Consultant Psychiatrist)

The shift to community based interventions was largely favoured, but most thought that there would always be a need for a small cohort of beds for people who really needed to be admitted. A Community Mental Health Nurse explained the reason why the shift from institutionalisation had been slow, especially with regards to the recommendations arising from A Vision for Change:

I don’t think it had the influence we had hoped or thought… I also think the idea that this hospital I work in would close terrifies people, what is going to happen and I am not skilled enough because they didn’t maybe all stay as up-skilled as maybe they could have…there seems to be a desire to hold on to hospital settings… I think people feel they feel they lose status… if you don’t need a hospital then what are you.

The shift to the biopsychosocial approach to practice was also discussed, indicating its prominence in professional discourse:

‘Our approach…our goals for the patient, and the patient’s own goals, are very different from what they would have been historically…there is so much more we can offer…the specific set of problems which the patient has, are never going to be solved with medication. (General Practitioner)

It’s a less medical model now…more holistic…we all talk about the biopsychosocial model, but I suppose the idea that it would be embedded down in terms of resourcing…its evolving. (Clinical Psychologist)

Thus, the approach to practice was shifting according to the participants. It was not just about medication, but looking at the whole person and at a range of psycho-social factors.

The inter-professional approach to recovery

The inter-professional approach to practice emerged as the third theme. A number of the participants described their views on its value:

Looking at the individual world across the lifespan…adaptation to the difficulties that are there also that new learning kind of…that’s through the multi-disciplinary part…that helps to keep a recovery focus emm, you know, at the centre I think.’ (Clinical Psychologist)

It was very medical orientated…no occupational therapy, very little social work…community nurses ran around doing what the consultant said…the reason that existed is that it was all there was…In my team we are very recovery
orientated...patient being self-directed in the overall recovery. (Community Mental Health Nurse)

When you are on a team everyone is very open...nobody dictating over another person...because the MDT member is coming from different backgrounds you can cover many aspects of a person’s life. (Occupational Therapist)

According to the professionals, integrated working fostered a holistic approach to recovery. In the past, the stance was very much medicalised because there were few other disciplines involved with the service user. By taking into account the holistic view of the person, far more areas of well-being could be considered. Such changes were applauded:

I think it’s a huge step forward...how consultants value their team, or rely on their team, look for input from their team...while there is potential for conflict I think it’s actually working a lot more often than its not...much easier to practice with a team around you. (General Practitioner)

You would still have the doctor as the lead of the team...all the new referrals...come through the doctor and then it is out to who it is best to deal with this individual. (Occupational Therapist)

The professionals still felt the doctor should rightly take the lead. Nonetheless, they stated how they were valued by the consultant, and how casework could be apportioned to individual members of the team. The Consultant Psychiatrist pointed out the role played by the members of his team as follows:

When you have eh, ehh a wonderful team as I do...they do things that I don’t think I would be able to do...skills that some of the CPNs have...similarly with social work...with OT and psychology...you have the right people giving the right intervention...to achieve the maximum benefit.

Professionals on the team felt valued according to the Psychiatric Social Worker:

Multidisciplinary works well because we kind of a take each other’s view in to account...embrace them...we don’t always agree on how things should go forward...there’s always at least a good discussion...a good forum, to make your view known.

The inter-professional approach to practice worked well, with open, collegiate discussion and debate on cases. This view was emphasised by a Community Mental Health Nurse:

Now as a team, we’re sitting down...working as a whole...we’re becoming more recovery focused...MDT meetings which I swear, is probably the best meeting we put in all week...where we all kind of a throw it out there, trash it out and work together in the different areas and put supports in place...you know, you’ll get different ideas and so that it’s not just all that whole medical side.

Risk management as a factor influencing recovery

This theme centred on the idea of risk, its impact on recovery, and how it was managed. According to some of the professionals who participated, a modicum of risk-taking was empowering and warranted within a recovery perspective:
If you go the other way and not putting the patient at the centre of it...sort of passive...I think it actually increases riskiness...unrealistic and dis-empowers the person...a good eye needs to be kept in that area of risk...I think the way that we do that...that kind of skill area...we've learnt over time is, talking about it, putting the person right in there you know, being open about it...better outcomes...with recovery. (Clinical Psychologist)

I think that we have to run the risks of making a mistake, erring on the side of caution to me would actually be taking the risk...we have to take intelligent risks, educated risks...give people the chance to succeed...if we are going to be afraid of risk...we are never going to get anywhere. (Community Mental Health Nurse)

Essentially, it is about being aware of risks but at the same time taking them to promote human well-being. If professionals did not take these risks, service users could become disempowered contra recovery. They need to be given a chance to succeed, because it was seen to have better outcomes within the recovery model. It was not about ignoring risk, but taking intelligent and well thought out risks. Ultimately, risk was something which was always present:

That’s part and parcel of our jobs and we can become fearful of risk I suppose...we take risks all the times, we see a patient, we risk assess...you can risk assess but it’s a tick box exercise...you can only go on what a person’s saying at that very given time...it’s about getting to know the patient and building up a relationship...we need to take risk... (Community Mental Health Nurse)

It was important that risk did not overwhelm the professionals leading to over-defensive, cautious reactions. In dealing with the issue of risk and managing it, it was vital that there was good team rapport. Furthermore, risk decision-making had to be inclusive, involving the team and service user. It was about having a safety plan in place.

**Service user involvement and responsibility**

The final theme centred on the service user and their optimal involvement in their own recovery. For the participants, the service user should be the pivotal actor in the recovery plan:

We are coming to realise that the patient should have a choice in every area, same as all of us should have...we weren’t offering people much more than just tablets...we are not just inflicting recovery on people, we are stating with it...if you don’t want to go in that direction that is your choice. (Community Mental Health Nurse)

The recovery model and from at least what I understand is that the individuals themselves are responsible for their own wellness...there is, an expectation that, because you come to a doctor...is going to do something for and in the end everything is going to be resolved. (Consultant Psychiatrist)

Thus, the service user was afforded choice as to how they wanted to recover: they were the central drivers in the change process. The expectation in the past would have been that the doctor had the answers, that he/she would solve the problems. This idea of service user involvement could be a struggle for some people as regards the expectation and responsibility on them to participate in their recovery:

Patients don’t really like that, they just want the doctor to say a, b and c and patients have to make that change and society....sometimes it had to come from within the person and their social sphere...the patient needs to be given a sense of responsibility from the beginning. (Community Mental Health Nurse)
I think with patients have, are coming out of institutions...I think they find it em, difficult to emm, I think they are quite scared about that concept...they find it quite difficult to apply it to them because they, they have been told for so long that they are unable, that they believe it themselves...and figure out actually, I do have a voice...I do have things in life that I want to achieve. (Psychiatric Social Worker)

It seems, then, that service users can become accustomed to being labelled mentally ill, that it can give them a sense of identity, a sense of belonging. This can result in a challenge for professionals in motivating and empowering people to take control of their own recovery.

Discussion

It is clear that the concept of recovery did not have a one-dimensional meaning. The literature would support this finding coining it a “polyvalent concept” (Pilgrim & McCranie, 2013, p.39). Moreover, it has been viewed as a socially constructed conception determined by how someone envisons the world, their epistemological position and wider socio-medical discourses (Chester et al., 2016). Of interest, is the fact that clinical discourses (linked to medicine) still have some influence in this social construction. Yet, we noted that themes such as poverty, structural disadvantage, social cleavage and social stratification were not prominent in the data, suggesting the need for a wider conceptualization of the nature of the ‘social’, and its impact on mental health.

More widely, the literature adduces that recovery can take various forms (Gehart, 2012) and this breadth of perspective was acknowledged by the Clinical Psychologist who viewed it in terms of building people’s skills. The notion of entering a personal journey was also foregrounded. Such perspectives are supported in the literature, most notably in the publication, Mental Health in Ireland (Higgins & McGowan, 2014). That said, it is evident that such openness to multiple meanings can result in a vague understanding of what recovery should look like in practice (Pilgrim & McCranie, 2013).

This study revealed that there was a general consensus of what recovery meant overall, but it was evident in the findings that when the consultant spoke about recovery it was more medicalized than the perspective of the social worker, for example. Still, the professionals viewed the definitional process as collaboratively constructed, rather than as prescriptively driven. This supports the idea evinced in the literature of a move away from paternalism; professionals are becoming facilitators and co-producers, involving a shift in the meaning they attribute to recovery (Cleary & Dowling, 2009; Sowers, 2005).

Importantly, the findings indicate various shifts in thinking about mental health services. Previous studies have identified the need for a similar change in attitudes, culture and power. For many years, mental health services were “hierarchical in nature” (Gaffey et al., 2016, p.2) making such shifts problematic. Looking at the findings, it would seem that this move to a humanistic understanding is progressing well in the sample compared to the evidence of stasis in other sectors. Notably, the majority of the professionals working within the inter-professional team stated that recovery was about people regaining control over their lives, and fulfilling their potential.

One of the other main shifts has been the move away from institutionalisation to community-based alternatives. The most recent policy document, A Vision for Change, has called for the complete closure of institutions (Brennan, 2014). The findings in this study would support the
idea of community-based approaches to practice being the way forward. However, a number of the participants highlighted the importance of some inpatient beds remaining for people who were acutely unwell.

When reflecting on shifts in practice, a number of commentators argue that the biomedical approach is still dominant, undermining the role of psycho-social factors (Brosnan & Sapouna, 2015; Higgins et al., 2012; Keogh et al., 2014). Furthermore, policies and services can endorse a recovery philosophy, but implementing it in practice is another matter (Walsh et al., 2008). Nevertheless, the findings collected by the researchers suggest that this power imbalance is shifting in the sample studied highlighting the crucial role played by the inter-professional team. The professionals identified how working together enabled them to look at the person in terms of a lifespan perspective. In the past the approach would have been very medically driven, but now there was a much more rounded approach to cases. Therefore, the findings support what the literature says regarding the role of the inter-professional team implementing a biopsychosocial approach.

Furthermore, according to the participants in this study, it was working well in practice. A central theme emerging from the findings centred on risk and risk-taking. The notion of risk was associated with the dominance of the biomedical model in years gone by (Davidson et al., 2016). Pilgrim (2008) argued that there was a preoccupation with the concept of risk and how to minimize it. Furthermore, a culture has developed that is focused on risk, dangerousness and protecting the public (Nash et al., 2014). However, in this study we discovered that, by not taking risks, mental health professionals believed they were actually increasing it. Thus, and interestingly, there was a sense of the need for positive risk-taking to promote growth and individual responsibility. Moreover, for the professionals interviewed, it was about making informed and educated decisions around risk. People must not allow it to overwhelm them, as commented on in a number of studies (Holley et al., 2015; Tickle et al., 2014).

Lastly, in our findings we noted how the shift to recovery-orientated practice had been challenging for professionals. This was because it involved the service user becoming the expert in their recovery – a theme endorsed widely in the literature (Gaffey et al., 2016; Hungerford, 2014; Sowers, 2005; Walsh et al., 2008). This is a notable shift from professional paternalism (Sowers, 2005). In this study, the professionals stated that service users were being placed at the centre of their recovery plan. It was no longer just about medication. People were being given autonomy over their lives which is a key objective of mental health policy in Ireland (Department of Health and Children, 2006).

**Conclusion**

In terms of limitations pertaining to the study, the data collected may not be representative of the perspectives of other multidisciplinary teams in Ireland. Moreover, it was limited in its reach and scale. Without interviewing a sample of service users, we were only able to attain the professionals’ perspectives. This lack of triangulation might have led to an incomplete picture of how recovery was operationalized. A more in-depth social constructionist study, employing discourse analysis, might have led to a deeper understanding of how knowledge was being developed and deployed. Nonetheless, our study captured important perspectives from different disciplines at a time when the notion of recovery is gaining ground in mental health policy and practice.

Our findings also shed some light on the potential mismatch between what policy says, and how it is implemented in practice. Importantly, although there is a large body of knowledge
surrounding recovery internationally, there is an underwhelming collection of primary data and findings in Ireland, from the perspective of the professionals working within mental health services. According to the literature, this is still a current debate, and we contend that our study has provided a modest contribution to this emerging field of inquiry. In spite of its small scale, this research reveals a positive understanding of how recovery is being socially constructed and how it should manifest in practice. Ultimately, recovery must revolve around a shared understanding of the service user’s narrative and aspirations for the ‘good life’. It is a process of humanistic engagement rather than a unitary act of mechanistic co-production: a journeyed river of participative consciousness as opposed to a discrete landing point.

References


