

Conference Proceedings

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Lothian Recovery Network

WHAT DOES RECOVERY MEAN IN EDINBURGH AND LOTHIAN

Paper

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**Abstract**

The concept of recovery in mental health practice is gaining growing interest and support both nationally and internationally. Recovery is not a new idea. Practices that reflect recovery oriented values - hope, finding purpose and meaning in one's life, taking responsibility for one's life, amongst others - can be traced as far back as 1796 with the foundation of the York Retreat by the Quaker Tuke family. However, over the last few years, recovery has increasingly gained acceptance within the mental health sphere. This has mainly been due to the championing of recovery by people with lived experience of mental health problems, based upon the recognition that recovery represents a more positive and empowering approach than traditional ways of dealing with these matters. This increasing acceptance is growing in Scotland, reflected, for example, by government support for the Scottish Recovery Network. The national learning materials *Realising Recovery* published in 2008<sup>1</sup>, have also provided a rich teaching resource, allowing learners to build on and to extend their knowledge beyond the 10 Essential Shared Capabilities for Mental Health Practice.

This paper describes how Lothian Recovery Network developed their own recovery course, (now accredited with Edinburgh Napier University) based on these national learning materials, against the backdrop of the national and international history of the survivor movement. Crucial to the development and running of the course is the input of people with lived experience of mental health difficulties, who comprise at least half of the team of around 20 trainers. The paper describes how, to a person with lived experience of mental health difficulties, participation in the development and delivery of the course, has influenced his journey of recovery and growth. In particular, by participating in the development and facilitation of the realising recovery module, he has reduced his feelings of isolation and social exclusion; bolstered his confidence and sense of self-esteem, and found a new sense of hope and purpose in his life. In turn, he has been able to use this enhanced sense of recovery as an educational tool. By describing to participants in the *Realising Recovery* course how his own involvement as a facilitator has enhanced his own sense of well-being, he is able to illustrate the benefits of recovery-focused values.

The paper ends by showing how experiencing the course and its contents can provide an interesting illustration of recovery as a *threshold concept*, using Glynis Cousin's development of Meyer and Land (2006), where the 5 key features of a threshold concept are being: transformative, irreversible, integrative, bounded and involving 'troublesome knowledge' (ref: Cousin, G (2006), An introduction to threshold concepts, *Planet*, no. 17, <http://www.gees.ac.uk/planet/p17/gc.pdf>).

That recovery is *transformative* as a process can be in little doubt. The growing evidence from personal narrative shows time and again how new understandings about the nature of recovery involve an ontological as well as a conceptual shift – recovery is assimilated into the person’s biography. That recovery is often *irreversible* can be illustrated, in terms of the present paper, by the commitment of recovery network members and facilitators – a certain solidarity is evident. Once committed to a recovery approach, for most, there is no going back. The *integrative* nature of recovery, that is, its ability to allow connections that were hitherto hidden from view, is evident in the way diverse aspects of the course unite under recovery as a concept – these range from the use of language, through use of self in recovery-focused relationships, person-centredness, self direction, positive risk-taking to connecting with community. As a threshold concept, recovery is *bounded* in that it will have frontiers bounding with other conceptual areas. We are reminded here by Cousins that we should avoid any tendency towards seeing a threshold concept as a form of disciplinary property that invites “congealed understandings.” In practical terms this might mean the need to avoid the common tendency of seeing recovery as a model, but rather keep it open, creating a “space for questioning the concept itself” (Cousin, p. 4). Finally, recovery inevitably involves *troublesome knowledge*. It is troublesome for a range of reasons. For example, it is difficult for some people to accept that anyone can recover from a mental health difficulty, or that recovery doesn’t mean going back to how you were before, but rather living well in the presence or absence of mental health difficulties. Recovery involves examining issues of power and this is perhaps the most troublesome aspect of it for some.

Reflecting upon the experience of the conference and, in particular, the various workshops that took as their topic the teaching of recovery values and practices, we were particularly struck by two things. Firstly, based upon the reaction to our presentation, there appears to be a real interest in recovery but a lack of knowledge by some about the topic. Secondly, based upon participation in other workshops with a recovery theme, we have the impression that a variety of educational methods are being used to teach students about recovery. Two examples illustrate this second observation. Firstly, in Huw Richards’ work at the University of Worcester, digital video clips of people talking about their own lived experiences are used as part of a distance learning course exploring ideas around recovery. Secondly in the work of Margaret Conlon and Gwenne McIntosh at Edinburgh Napier University, concept maps are used to help students explore the complexities around recovery – including issues around “troublesome knowledge”.

One wonders whether the above observations reflect an uncertainty in academia about the nature of recovery, in turn, posing questions about evidence base. Although there is strong qualitative evidence for recovery - particularly via the use of narrative research studies, there remains little quantitative evidence. This may be due, in part, to the nature of recovery itself. As recovery is widely regarded as unique and self defined by each individual, this may mitigate against establishing applicable indicators that can be generalised to wider populations.