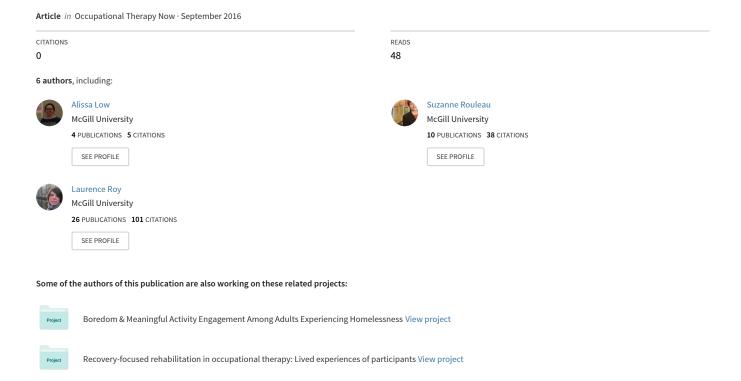# Students' reflections on recovery in research and clinical practice: Lessons learned and unanswered questions

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Students' reflections on recovery in research and clinical practice: Lessons learned and unanswered questions

Alissa Low, Christine Daniel, Catherine Auger, Rachel Kadoch, Suzanne Rouleau and Laurence Roy

In the past decade, mental health policies in Canada have shifted toward recovery-centred approaches (Mental Health Commission of Canada [MHCC], 2012; MHCC, 2015). As students in a professional master's program in occupational therapy, the keywords or concepts of recovery, such as those of the CHIME model: connectedness, hope and optimism, identity, meaning and purpose, and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011), offer direction for our mental health practice. With these ideas in mind, we welcomed the opportunity to spend the summer of 2015 conducting a research project consisting of interviews with adults who experience severe mental illness attending a recovery-oriented outpatient program. The interviews offered insights into what recovery means for participants and extended findings of other studies examining the relationship between occupation (meaningful daily activities) and mental health recovery (e.g., Kelly, Lamont, & Brunero, 2010; Lloyd, Wong, & Petchkovsky, 2007). This paper focuses on some unexpected learning with regard to our efforts to do recovery-oriented research. Throughout this paper, we will explore two facets of this experience: first, the ethical tensions we faced, and, second, how questions related to the integration of research and practice were left unanswered.

Ethical tensions

Considering the degree of "moral complexity of contemporary professional practice" (Kinsella, Park, Appiagyei, Chang, & Chow, 2008, p. 176) in mental health service delivery, it may be not surprising that we experienced both micro-level and macro-level ethical tensions during our research endeavour. At the micro, or interpersonal, level, we noted two complexities when preparing our study. The first complexity aligned with Lal's (2010) critical perspective indicating that one's worldview influences one's use and understanding of the term "recovery"; thus, we reflected that our ideas of recovery were influenced by our curriculum material. More specifically, one of our readings from Leamy et al. (2011) described recovery as a personal experience, rather than a series of measures imposed on individuals by the mental health system. We were also influenced by the writings of Patricia Deegan, who posited that "recovery is a process, not an end point or a destination. Recovery is an attitude, a way of approaching the day and the challenges I face. . . . I know that I have certain limitations and things I can't do. But rather than letting these limitations be an occasion for despair and giving up, I have learned that in knowing what I can't do, I also open upon the possibilities of all the things I can do" (Deegan, 1997, pp. 20-21). As cautioned by Drake and Whitley, the second complexity consisted of the possibility of recovery as a new "catchphrase" (2014, p. 237), as new approaches may sometimes replicate traditional ways of providing mental health services.

Thus, at the micro level, with these perspectives of recovery in mind, we attempted to minimize our influence on research participants' definitions of recovery. One strategy to reduce our influence was to omit the word "recovery" from interview questions. However, we found that the use of our learned biomedical language was deeply ingrained into our world view and it quickly became default language in situations of uncertainty. For example, in an attempt to describe recovery in some interviews, we compared the recovery process for mental illness to the recovery process for a broken wrist. We soon realized how our unintended use of language influenced the conversation before we were able to truly hear participants' perspectives of recovery. As we considered the interplay between the micro and macro (systems-level) perspectives, we were left with the unanswered question of how mental health service providers actually use the language of recovery, as "the language of recovery may not be seen to reflect people's historical, linguistic or cultural background and experience" (MHCC, 2015, p. 10), and recovery aims to "[represent] the interests of people living with mental health problems and illnesses, to ensure that their voices are heard" (MHCC, 2012, p. 121).

From an organizational-level perspective, an ethical tension was identified by participants regarding interest in having an informal social space in the outpatient department for use during the discharge transition process in or out of the hospital. Some participants expressed that social connections were made in the outpatient department, however, they did not feel ready to access similar informal services within a community setting. Tew (2013) established the therapeutic benefits of belonging and engaging socially as ways to reclaim ownership of one's life—our participants showed us that realizing this sense of belonging can be difficult to achieve in a community setting. Interestingly, Slade et al. (2014) expose an "abuse" of the recovery orientation in eliminating services that are institution-based toward a more community-oriented setting. We were faced with the dilemma of which voices to listen to. Should there be an informal, social space in the outpatient department when such spaces are offered in the community? Even if there was consensus on the benefits of an informal social setting at the outpatient department, there

would not be enough resources to make this happen due to recent budget cuts. Given this constraint, we wondered if this identified need could be met in other ways.

This scenario leads to one final, macro-level ethical tension that highlights the dilemma faced by recovery-oriented programs that lack the resources to move beyond individual-level interventions. We empowered participants to voice their desires for services that they believe will promote their personal recovery, yet we are not empowered ourselves as clinicians or researchers to be able to offer these services. For example, how do we reconcile the need for participation in paid work or community-based activities (e.g., arts), as discussed in the recovery literature and in the narratives of participants, with the inability to implement evidence-based recovery-oriented interventions such as individual placement and support, or access to peer support (Slade et al., 2014)? Thus, what becomes of our support for recovery interventions if our work with individuals is unable to actualize what Deegan (1997) describes as "the possibilities of all the things I can do."

Integrating research and clinical practice under a recovery framework

Our study prompted us to reflect on the research process itself as a strategy to remain critical of our own recovery orientation. As future practitioners, we argue that putting in place mechanisms that allow for continuous engagement in research in our workplaces is crucial for the development of professional skills such as critical reflexivity and advocacy. What could these mechanisms look like? We believe there is a need for more discussion about the value of research in everyday occupational therapy practice and about the responsibilities of practitioners, employers and universities in fostering this integration of research and clinical practice. Such integration would allow practitioners and clients to explore and discuss in greater depth, among other things, macro- and micro-level ethical tensions such as we observed in our study. By conducting our research study, we were able to develop a critical perspective on recovery, apply reflexivity, and experience, firsthand, ethical tensions that occurred in doing recovery-oriented research. Further, we are now more aware of the need to take the time to listen and allow clients to direct their own recovery in their own language. As new occupational therapists, we hope to continue practicing

critical reflexivity and seeking perspectives of people with lived experience, relating to both individual- and systems-level matters. The complex question of how to advocate for such tight integration of inquiry and practice remains a topic for future discussion.

Acknowledgements

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About the authors
Alissa Low, MScA OT, Christine Daniel, MScA OT, Catherine Auger, MScA OT, Rachel Kadoch, MScA OT, Suzanne Rouleau, MSc, and **Laurence Roy, PhD,** conducted the original research study in the summer of 2015 as part of the first four authors' degree requirements in the occupational therapy master's program at McGill University. They may be contacted at: alissa.low@mail.mcgill.ca

The intention of this special issue of *Occupational Therapy Now* is to provide a broad audience, including occupational therapists, health professionals, clients, policy makers, the general public and other stakeholders, with information on the role of occupational therapy in recovery-oriented psychosocial rehabilitation. This issue is open access and available online at: http://www.caot.ca/default.asp?pageid=4074 Please share this link widely!