Social recovery: a new interpretation to recovery-orientated services – a critical literature review

Michael John Norton and Calvin Swords

Abstract

Purpose – *In 2020, the significance of "lived experience" and "service user" accounts of recovery has become central to the delivery of mental health policy and practice. Reflecting on the first known account of personal recovery in the late-20th century provided new hope and encouragement that those living with mental illness could live a fulfilling life. Taking this into consideration, the purpose of this paper is to explore the relevance to this experience of those using services today.*

Design/methodology/approach – *The authors present a critical literature review, which is underpinned by a systematic approach adopted from Higgins and Pinkerton (1998). This involved a six-step approach seeking to answer the question – What are the service users' views on the recovery concept within mental health services?*

Findings – *The conceptualisation of recovery continues to focus on biomedical parameters. A new interpretation of recovery is beginning to materialise: social recovery. This new interpretation appears to be achievable through six key influencers: health, economics, social interaction/connection, housing, personal relationships and support.*

Originality/value – *Building on Ramon's (2018) argument regarding the need for mental health policy to focus on the concept of social recovery, this study extends on this proposition by providing a foundational evidence base. More specifically, it not only supports the need for this shift in policy but also identifies a new interpretation building in practice. Furthermore, the authors highlight six key pillars that could potentially shape such provisions for policy.*

Keywords *Social recovery, Mental health, Lived experience, Policy, Peer support*

Paper type *Research Article*

Michael John Norton is based at the Waterford Institute of Technology, Waterford, Ireland, and National Engagement and Recovery Lead, Recovery College South East, Kilkenny, Ireland.
Calvin Swords is based at the School of Social Work and Social Policy, Trinity College Dublin, Dublin, Ireland.

Introduction

In 2020, we are at a critical juncture regarding mental health policy and practice. The recovery movement and the shift towards recovery as a personalised journey are well documented within the literature. There is a global recognition that services need to become recovery orientated, with many services co-producing and implementing national policies on the process (Swords, 2019; Swords and Houston, 2020).

For many, this philosophy remains aspirational and tokenistic because the biomedical model still remains the dominant approach to mental health service delivery (Brosnan and Sapouna, 2015; Swords and Houston, 2020). Throughout the westernised world, there is evidence of modification rather than transformation. The development of the concept as a personalised journey dates back to the work of Patricia Deegan in the 1980s. Here, she explained that people who have experienced mental health difficulties must accept the debilitating nature of their illness, but yet, recovery can be discovered and built through a person's new identity, a new sense of self (Stacey and Stickley, 2012).

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There have been many depictions of the concept since 1988, with many underpinned by a similar philosophy to Deegan (1988). These include:

> *It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by illness* (Anthony, 1993, p. 15).

> *A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles* (Perkins and Slade, 2012, p. 29).

Taking these into consideration, recovery is an individualised journey taken by the person who experiences mental health difficulties. It is a subjective, unique experience for each person that can only be measured by the person themselves (Pilgrim, 2008; Ramon *et al.*, 2009).

The subjectivity of recovery is significant within the process. If people cannot be listened to, accepted and supported to follow the recovery journey of their choosing, are mental health services not just maintaining control and power over service users? Institutional culture and organisational commitment to recovery are fundamental to changing attitudes, beliefs and opinions (Cleary and Dowling, 2009; Gaffey *et al.*, 2016; Swords, 2019; Swords and Houston, 2020).

Therefore, the purpose of this paper is to compare Deegan's (1988) understanding of recovery with what service users are saying in 2020. Is there new learning to be taken from how mental illness and recovery should be understood in 2020? What are the significant discourses at play in how those using services express their feelings and experiences of recovery and mental illness?

Method

This paper aims to explore the service user perspectives of recovery in mental health. Consequently, this article presents a critical review of the literature in relation to this hypothesis. The researchers adopted a six-step systematic approach extrapolated from Kathryn Higgins and John Pinkerton (Iwaniec and Pinkerton, 1998). It is important to note that although the search presented below is systematic in nature, this review does not fall under a systematic review as the PRISMA statement (Moher *et al.*, 2015) was not used.

This method incorporates narrative review techniques with more contemporary formulations known as the science of systematic reviews. Essentially, although this is not a systematic review, a systematic approach has been taken to this critical narrative review (Higgins and Pinkerton, 1998). This approach is rigorous, methodical and systematic. It consists of six steps (Higgins and Pinkerton, 1998). Step 1 involves a clear overview explicitly outlining the purpose of the review. Higgins and Pinkerton refer to this as the mantra statement. Essentially, what is the contribution of the study. The researchers are seeking to explore what service users are saying regarding recovery in mental health in 2020 (Higgins and Pinkerton, 1998).

Step 2 shifts the focus from what and why of the research, to how. This involves every decision in the review process. At the time of writing, both authors were completing their PhDs in recovery and mental health. One focusing on the impact of peer support workers (PrSWs) on mental health services. The other exploring the potential impact of social constructionism on recovery-orientated services. Therefore, based on their own literature reviews, both researchers posed the question – What are the service users' perspectives on the recovery concept within mental health?

The researchers agreed that a critical review of the literature on this question could provide new learnings in both literature and practice. Given the vast array of literature regarding recovery, the researchers adopted inclusion/exclusion criteria to increase

Table 1 Inclusion/exclusion criteria

Inclusion	*Exclusion*
Service users	Service providers, family members, carers
Qualitative/mixed-method literature/literature reviews	Quantitative literature
Definitions of recovery	Discussion on clinical recovery
Recovery concepts	Addictions, physical health
Mental health	Meta-synthesis
English language	Periodicals, discussion papers
Adults over 18 years	Children

the specificity of the study's focus (Table 1). The researchers focused on electronic peer-reviewed articles from several databases: Applied Social Science Index and Abstracts, PubMed, Web of Science, Social Science Premium Collection and EBSCO (PsychINFO, PsychTESTS, PsychARTICLES, MEDLINE, CINAHL, AMED and Academic Search Complete).

Step 3 involves the development of a comprehensive database search. The researchers were supported in this process by the work of Kugley *et al.* (2016). They used the PICO method to build search strings for each database (Richardson *et al.*, 1995; Melnyk *et al.*, 2010). This method supports the researchers to manipulate key terms of the research question to provide accurate results. The PICO abbreviation supports the researchers in developing a research question by identifying the **p**atient or **p**opulation, **i**ntervention or **i**ssue, **c**omparison and **o**utcome (Richardson *et al.*, 1995; Melnyk *et al.*, 2010). For transparency and rigour purposes, the authors provide a detailed synopsis of the search strategy, including search strings and the process of deduction (Appendix 1).

Step 4 involves the selection of articles from the search results. The researchers discussed the need to be as specific as possible with the results. The researchers divided the databases between them and used the inclusion/exclusion criteria to further reduce the search results. They cross-examined each other's application of the inclusion/exclusion criteria to results, which increased rigour and trustworthiness. The researchers adopted a grading system for database results, from low to high priority. High-priority articles were those that focused on mental health, recovery, service users and co-production (Higgins and Pinkerton, 1998).

Step 5 involves the synthesising of results and drawing conclusions from the final list of articles (Bruce, 1994; Higgins and Pinkerton, 1998; Ridley, 2012). Step 6 involves the researchers reflecting on the research question posed so that they have represented a clear depiction of how they reached this conclusion (Higgins and Pinkerton, 1998).

Quality appraisal

An adaptation of Hawker *et al.* (2002) critical appraisal tool was used to assess study quality. The tool originally comprised of nine questions in which answers were rated from good to very poor. However, Lorenc *et al.* (2014) adaptation converts these ratings into numerical values, resulting in a score that measures study quality. Each study could receive a minimum of nine up to a maximum of 36 points allowing for study quality to be graded (Lorenc *et al.*, 2014). This tool allowed the researchers to validate included papers as it initiated a process whereby the researchers could reflect on these studies systematically.

Analysis

The researchers adopted Braun and Clarke (2006) thematic analysis for the data. This involved the researchers becoming familiar with the data through many readings of the included articles. Initial codes were generated and discussed, resulting in themes. These were revised, adjusted and refined by the researchers. The process was supported by critical engagement from both researchers with their own subjectivities and pre-conceived ideas about the research question under enquiry and supported through reflection.

Findings

Initially, there were 62 hits that related to mental health recovery. This was narrowed down to 44 potential studies based on the research question, after which, strict inclusion/exclusion criteria and methodology were applied, based on the work of Higgins and Pinkerton (1998). After this, a final tally of four studies remained (Figure 1).

Studies consisted of three research papers and one literature review with first-order constructs attached. Out of the three research studies, two papers reported mixed-methods. The final paper was a qualitative study. It is important to note that the researchers only used qualitative data relating to all four included papers. This stance was taken because the subjective experience of the service user can only be truly explored through qualitative accounts of meanings that cannot be adequately represented through numerical values (Bryman, 2012; Willig, 2013; Robson and McCartan, 2016). From these papers, one focussed on PrSWs and how they, through co-produced groups, enabled recovery; one paper focussed on recovery whilst being involuntarily detained; and one focussed on how recovery colleges support the recovery process. The final paper examined the treatments, care and support necessary for the individualised recovery process to occur. All papers were based within a mental health setting, with no papers originating from the forensic setting. Further information on study characteristics can be found in Table 2.

In terms of study quality, all included papers underwent a rigorous appraisal process. From this, one study received an A grade, two studies received a B grade and the final paper was awarded a C grade (Table 3). No papers were eliminated resulting from a poor grade. However, this process allowed the researchers to consider validity in all papers systematically. Regardless of methodological orientation undertaken, all

Figure 1 Selection process for relevant papers

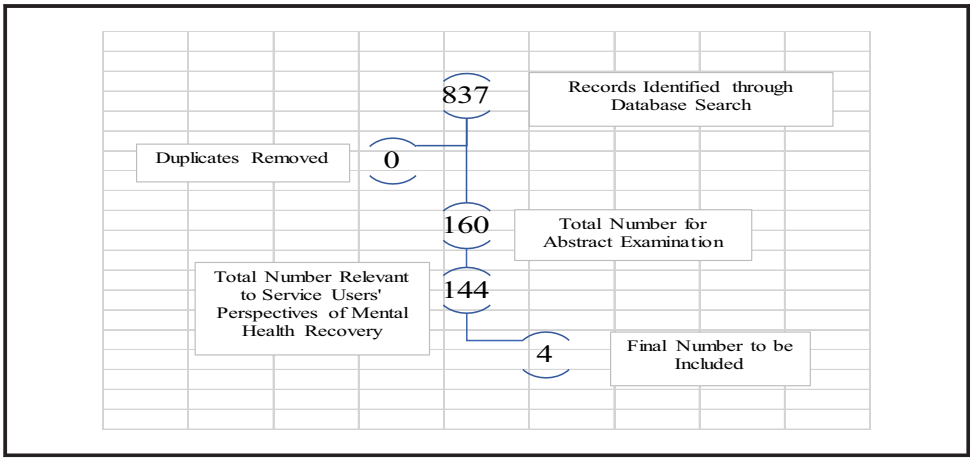

Table 2 Table of cross-study display for comparative appraisal

Author/year/ geographical location	*Study aim*	*Sample size/ age range*	*Type of diagnosis*	*Research design*	*Theoretical orientation*
Brophy *et al.* (2015) Australia	To identify the priority of treatment along with what supports and service personnel those with psycho-social disabilities value in their recovery journeys	41 27–63 years	Mental health	Mixed-method study	*N/S*
Ford *et al.* (2015) UK	To add to the growing evidence base around improvements within acute mental health settings through the experiences of involuntarily detained service users	*N/A*	Mental health	Literature review with first order constructs from author	*N/S*
Sommer *et al.* (2018) Australia	To explore the multi-stakeholder experiences of participation in a regional recovery college as both teacher and student	29 *N/S*	Mental health	Qualitative study	*N/S*
Taylor *et al.* (2018) UK	To evaluate a co-produced recovery group: "Enabling Recovery" to support service users in their recovery	23 19–64 years	Mental health	Mixed-method study	*N/S*

Notes: This table shows details of all included papers for the purposes of aiding the researchers with the cross-study comparative appraisal. *N/S* = not specified. *N/A* = non-applicable. Theoretical orientation = the theory that shapes the author's perspective in writing the paper

Table 3 Critical appraisal for validity using Lorenc *et al.* (2024) critical appraisal tool

	Items										
References	*Abstract/ title*	*Introduction/ aim*	*Data collection*	*Sampling*	*Analysis*	*Ethics/ bias*	*Results*	*Generalisability*	*Implications*	*Total*	*Grade*
Brophy *et al.* (2015)	3	3	3	2	4	2	3	2	3	25	B
Ford *et al.* (2015)	4	2	2	1	3	1	4	3	3	23	C
Sommer *et al.* (2018)	4	4	4	2	4	4	4	3	2	31	A
Taylor *et al.* (2018)	4	3	4	4	3	2	3	4	2	29	B

Notes: Table demonstrate the critical appraisal process for validity using Lorenc *et al.* (2014) adaptation of Hawker *et al.* (2002) critical appraisal tool

Table 4 Table of emerging themes and sub-themes from included papers

Theme	*Sub-theme*	*Included studies*
Recovery definitions	Biomedical	Brophy *et al.* (2015)
	New interpretations	Ford *et al.* (2015), Sommer *et al.* (2018)
Recovery influencers	Health	Brophy *et al.* (2015), Ford *et al.* (2015)
	Economics	Brophy *et al.* (2015)
	Social interactions/connections	Brophy *et al.* (2015), Sommer *et al.* (2018); Taylor *et al.* (2018)
	Housing	Brophy *et al.* (2015), Ford *et al.* (2015)
	Personal relationships	Brophy *et al.* (2015)
	Support	Brophy *et al.* (2015), Sommer *et al.* (2018); Taylor *et al.* (2018)

Note: This table shows the themes and sub-themes from included papers of this review

papers underwent the same rigorous appraisal process, as the researchers only sought to take qualitative data from included papers.

Two overarching themes were identified from the thematic analysis (Braun and Clarke, 2006). The first theme was associated with deciphering a universal definition for recovery in mental health. The second theme extrapolated the various influencers of recovery (Table 4). Both themes had subsequent sub-themes, which expands our understanding of recovery. These themes and their subsequent sub-themes are discussed further herein.

Recovery definitions

Two conceptual understandings to recovery in mental health were identified: the traditional clinical understandings and something new, which will be categorised as new interpretations. Each understanding has its own measurement criteria, which allows the observer to distinguish between them. This is evident, despite the fact that both understandings aim to allow the service user to live the best possible life even with their supposed diagnosis.

Clinical recovery. The definition of clinical recovery is entrenched within the biomedical parameters that are imposed on the service user by psychiatry. From observations of this approach, this perspective of the recovery process can be, and often is, paternalistic in nature. For example, Brophy *et al.* (2015) highlight that participants observed mental health challenges as long term, citing these challenges as ongoing psychosocial disabilities that participants expected to continue over a prolonged period. The effects of such disability are substantial, with Brophy *et al.* (2015) categorising them under three tiers: life-long learning activities, social interactions and employment. Each can cause service users to become more insular, creating an isolating and stigmatising environment, which serves as a negative loop. This loop has the effect of decreasing the likelihood of ever regaining a status in life that is acceptable to society and to the service user themselves.

New interpretations. Ford *et al.* (2015) focus on the experiences of service users who are involuntary detained. Despite this, participants identified several aspects of what constituted recovery within this care setting. These aspects surrounded living in an environment that is conducive of co-production. This was highlighted as a space whereby service users are involved in decision-making regarding their own care and normal everyday activities. This co-production stems from power sharing where service users are being listened to as equal (Ford *et al.*, 2015).

Sommer *et al.* (2018) add to Ford *et al.* (2015) findings regarding recovery definitions, despite the differences in settings and level of coerciveness. Here, they identify the importance of co-production through education and reflection of one's recovery journey through involvement in recovery educational activities. These activities are not conducted in isolation. They are completed with others who have similar experiences. This has the positive effect of allowing service users to gain more meaningful, unique and individualised interpretations of recovery.

Recovery influencers

Through thematic analysis, a second theme was extrapolated: recovery influencers. This theme highlights the aspects of human life that influences an individual's recovery journey. The results highlight six recovery influencers: health, economics, social interaction/ connection, housing, personal relationships and support.

Health. Health was highlighted as an influencer for recovery (Brophy *et al.*, 2015). Here, health refers to optimal mental, physical and social health. Participants in

Brophy *et al.* (2015) study stressed the link between these aspects of the health continuum, stating that it is the connection between physical, social and mental health that is important for the overall well-being of the individual.

This is further stressed by Ford *et al.* (2015) who highlight that due to the dictatorial approach used within coercive environments, other aspect of the health continuum deteriorates. For example, the participants' willingness to take control of their own health through advanced directives. Unfortunately, due to the setting described in Ford *et al.* (2015), service users felt powerless to such an extent that they did not complete an advanced directive. The rationale behind this is that service users perceived that staff within the approved centres would not take their preferences around treatment into account during service delivery.

Ultimately, even in acute settings, as explored in Ford *et al.* (2015), professionals and service providers need to facilitate open dialogue and support the service user voice. Capacity is a contentious issue, but there needs to be inclusivity of the service user's perspective and voice from the outset of their admission.

Economics. Economics, in this context, refers to financial stability. Brophy *et al.* (2015) identified steps that are required to gain economic stability, including education and employment (Brophy *et al.*, 2015). In terms of both steps, participants identified the need for support and encouragement regarding finding and maintaining suitable training/ educational opportunities and employment. From achieving these steps, economic/financial stability is maintained, creating a social persona of a functioning individual through various social statuses.

Social interaction/connections. Another recovery influencer is social interaction/connection (Brophy *et al.*, 2015; Sommer *et al.*, 2018; Taylor *et al.*, 2018). There are many ways to socially interact and gain social connections, e.g. engaging in positive friendships/social groups within the community (Brophy *et al.*, 2015). However, mental health challenges, as mentioned earlier, can leave one to feel isolated and act accordingly to increase this sense of isolation, unknowingly to the individual involved.

Therefore, reconnecting and re-engaging with social connections/interactions is necessary for one's recovery journey. As recovery involves many setbacks along the way, reconnections may be difficult due to past conflict with friends/family and other social support members. As such, repairing, sustaining and improving such relationships are necessary for ones' recovery (Brophy *et al.*, 2015).

Sommer *et al.* (2018) suggest a method of regaining social connection. They state that this is achieved by becoming involved in local recovery colleges. Sommer *et al.* (2018) found that such initiatives allowed for a social space whereby one can socialise without the fear of stigma. It is through these interactions/connections that a decrease in isolation occurs, thus supporting recovery (Sommer *et al.*, 2018).

Taylor *et al.* (2018) also suggest that support acquired by others is important for one's recovery. Social groups, like GROW (a peer support group for those with lived experience of mental health difficulties), were identified in this study as useful in recovery as service users, through sharing personal narratives realise that they are not alone. However, Taylor *et al.*(2018) highlight challenges to such groups, stating that disruptive group participants along with inadequate environmental facilities (i.e. seating etc.) can inhibit the positive effect these groups have towards social connection and interaction.

Housing. Brophy *et al.* (2015) highlight housing as another recovery influencer. Here, participants state that having appropriate accommodation was associated with personal stability, safety and independence. This association can be observed within Ford *et al.* (2015), where detainment to an approved centre was linked with the loss of autonomy,

independence, voice and decision-making capacity, all of which are well documented to hinder one's recovery.

Personal relationships. As stated earlier, within one's recovery journey, the process of repairing, sustaining and improving personal relationships is necessary to support the person's recovery journey (Brophy *et al.*, 2015). An example of this, as suggested by Brophy *et al.* (2015), is family relationships. This influencer of recovery can also support service users in developing other positive therapeutic and personal relationships via the support received by professionals. Through such supports, an added effect of meeting new people occurs, giving the person the opportunity to develop new and exciting relationships that are sustainable into the future (Brophy *et al.*, 2015).

Support. Three out of the four papers reviewed highlighted support as an influencer of recovery (Brophy *et al.*, 2015; Sommer *et al.*, 2018; Taylor *et al.*, 2018). However, they categorised the type of support available in their recovery process in two headings: social and purchased supports. Each has their own way of supporting one's recovery. We first examine social supports, which comprise free supports available in the community. After that, a focus on purchased supports will occur. This examines social supports that are given a monetary gain to be present during the service users' recovery journey.

Social supports. Social supports refer to voluntary supports within one's community, primarily delivered by fellow service users, e.g. mutual support groups, where attendees learn from personal narratives of others (Taylor *et al.*, 2018). Through such support, participants gain the confidence and motivation to seek out other community services such as regional recovery colleges (Sommer *et al.*, 2018; Taylor *et al.*, 2018). Within these environments, service users learn about recovery through the fusion of learnt and experiential knowledge. From this comes the opportunity for service users to take up the reigns, co-produce workshops and progress to employment/return to education (Sommer *et al.*, 2018). Furthermore, Brophy *et al.* (2015) state that social support does not necessarily need to come from fellow service user, but someone who could be responsive, consistent, respectful, available, compassionate, non-judgemental and accepting.

Purchased supports. According to Brophy *et al.* (2015), even with the many benefits of social supports, service users may benefit from more in-depth lived experience supports on a more formal basis. Such purchased supports come from the multi-disciplinary team and are used specifically to use experiential knowledge to support one's recovery journey. An ideal example of this, according to both Brophy *et al.* (2015) and Taylor *et al.* (2018) are PrSWs.

These supports are paramount in providing assistance regarding several recovery goals (Brophy *et al.*, 2015). However, PrSWs need to have certain desirable characteristics to be employed in such roles, including:

- The ability to introduce service users to a variety of social connections;
- to become a motivator/coach;
- to be the service user's advocate at multi-disciplinary team and care planning meetings;
- to use lived experience to help navigate the system; and
- to support family members/friends and listen to their perspective of recovery (Brophy *et al.*, 2015).

To be employed as purchased supports, one also needs to have three core skills, including:

1. an understanding of the impact of mental illness;

2. a personalised approach to support, based on experiential knowledge; and
3. the ability to examine and utilise the service users' values, skills, needs and preferences (Brophy *et al.*, 2015).

This, according to Brophy *et al.* (2015), can be achieved if such supporters have certain personal attributes, including:

- being responsive to the service users' and system needs;
- to be capable of providing continuity in care;
- to be respectful to others opinions;
- to be flexible to the service users' needs; and
- to be compassionate.

Discussion

Recovery remains a contested concept in mental health research. It is accepted that there are several competing philosophies from an ontological and epistemology stance. These propositions are further exemplified by the review findings.

Firstly, it is widely accepted that recovery is not just about recovering from symptoms. It is this holistic approach, combined with the person's wishes, that is key to how services should be delivered (Brosnan and Sapouna, 2015). The findings supports this, as there seems to be an acceptance that focusing on biomedical parameters alone is no longer acceptable (Brophy *et al.*, 2015; Ford *et al.*, 2015; Sommer *et al.*, 2018; Taylor *et al.*, 2018). Subsequently, this is a positive development where services are positioned regarding developing a recovery-orientated approach.

However, those using services are experiencing heightened isolation, stigma and disillusionment with their situations (Brophy *et al.*, 2015). Although the narrative is changing regarding how recovery is defined, the psychosocial interventions needed to support this transformation remain non-existent for many (Brophy *et al.*, 2015; Ford *et al.*, 2015; Sommer *et al.*, 2018; Taylor *et al.*, 2018). Therefore, service users are being re-introduced to a situation that views their identity and life as anomalous. Also, a narrative is augmented, which views the illness as the persons fault, a result of their deficits. Societal structures and institutions vitiate people living with mental illness to rebuild their lives. Therefore, it is positive that new interpretations of recovery are becoming significant narratives in services. The lacuna that remains is how this interpretation can be facilitated.

The requisite for a focus on social recovery is becoming ever more evident in debates (Brosnan and Sapouna, 2015; Ramon, 2018; Swords, 2019; Swords and Houston, 2020). There is a need for increased focus on developing and creating services that are not only focused on personal, but social recovery (Brophy *et al.*, 2015; Ford *et al.*, 2015; Sommer *et al.*, 2018; Taylor *et al.*, 2018). Some notable articles have referenced on various aspects of the influencers of social recovery discussed above. According to Sayce (2001), there is a clear link between mental ill health and what they term "social exclusion". "Social exclusion" here refers to low financial income and no means of employment. Similarly, Repper and Perkins (2009) have highlighted several of the influencers mentioned: economics, housing and health, but none of them within a social recovery context. Stickley and Wright (2011) explored relevant literature on what is being said specifically on the recovery concept. However, they do not provide any conclusive indicators that are needed for social recovery to transform mental health service delivery going forward.

Social recovery is philosophically addressed in a paper from Ramon (2018) who argues that the concept is overlooked due to its close association with the existentiality of personal recovery (Swords, 2019). Social recovery is focused on the collective culture within society, the opportunity for connectedness, as well as social and recovery capital. It focuses on seeking to understand the role of the political system, underpinned by the socio-economic agenda of a particular region or country (Ramon, 2018; Swords, 2019). Ultimately, becoming an active and participating citizen, with a sense of belonging, are key parameters of social recovery.

The findings of this paper support this perspective in the literature. The findings extend on the paper from Ramon (2018) by identifying the quintessential foundations for the process of social recovery to evolve – health, economics, social connection/interaction, housing; personal relationships and support (Brophy *et al.*, 2015; Ford *et al.*, 2015; Sommer *et al.*, 2018; Taylor *et al.*, 2018).

There needs to be a recognition in mental health policy provision and service delivery globally that social recovery is just as important as personal recovery. Otherwise, the subjective experience of mental illness shared by Deegan (1988) will remain aspirational. Service users' recovery journeys can be viewed as a shift from institutionalisation to community, with little agency other than to receive acceptance that recovery is no longer just a biomedical phenomenon in mental health.

Strengths and limitations

This review expands on Ramon's (2018) work into a new field of mental health recovery not previously addressed in mental health policy or practice. There are many influencers involved in social recovery, with each adding intricacies into a complicated process. Although the focus on social recovery was not the initial scope of this paper, based on the findings on service users' perspectives into the recovery concept, it is clear that, in 2020, social recovery is now vital to an individual's recovery journey.

The methodology used here increases the rigour and trustworthiness of the findings, as it is based on a methodological approach developed by Higgins and Pinkerton (1998). However, this approach limited the number of included studies in this review ($n = 4$).

Only one study received an A grade from critical appraisal, suggesting poor study quality. However, studies remained included as they added value to this paper. Also, despite methodological variations, all papers underwent the same appraisal process, as only qualitative data were included. Using the quality appraisal tools based on methodology may have altered the results of critical appraisal and added further values to the findings.

Although the authors acknowledge a vast array of grey literature into the recovery concept, the decision was made to exclude these papers to increase the quality and rigour of the present review. However, the authors of this paper identify the lack of review evidence for such grey literature, and this requires further exploration and investigation.

It is important to note that significant attention was given to Brophy *et al.* (2015) within this review. The authors' rationale for this, upon reflection, is perhaps because of the article focusing on the contribution of social work to personalised recovery-orientated care. The most pertinent explanation for this is that the mental health social worker role is to promote and advocate for the social perspective of a persons' recovery (Brosnan and Sapouna, 2015).

Ford *et al.* (2015) present a final limitation. The inclusion of a literature review here may weaken the findings of the review, as it relied on data that are three times

removed from the initial study participants. However, this paper was included, as there were first-order constructs attached from the reviewers, and much of the data was accumulated from this.

Implications for future research

This review introduces a new and undisturbed idea of recovery, which adds further intricacies into the concept. However, future studies should aim to confirm if these influencers are required for one to obtain social recovery and to further understand how the rise of this concept within the literature affects the future practices of mental health providers. As this review focussed on peer-reviewed scholarly articles, a number of key pieces of grey literature were not included. It would be worth investigating whether the influencers of social recovery found here have any basis within the grey literature.

Conclusion

Despite the low number of papers reviewed, this paper identified a new sub-type of recovery under this umbrella term. Social recovery is used to describe how one progresses from an identity associated with stigma and social deviance to a new socially acceptable identity. This new social identity is achieved through six influencers. Recommendations for further research are suggested particularly to grow the evidence base for social recovery along with confirming if these six influencers are appropriate in achieving social recovery outcomes.

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Appendix. Search strings

The search string used for each database

(Service user or client or patient or consumer or participant) AND (Recovery or rehabilitation or recovery model or recovery-orientated service or recovery focused or service user involvement or person centred) and (co-production or co-production of services) and (Irish Mental Health Services or Mental Health Services or Mental Health Context or Mental Health institutions or Mental Asylums)

1. ASSIA (Applied Social Science Index and Abstracts)

= 196 results

- Excluded literature reviews = 193 results
- Used subject filter "recovery" = 47 results
  = 33 available for download out of 47 results

2. Social Science Premium Collection
   = 431 results

- Excluded literature reviews = 428 results
- Used subject filter – "recovery"
  = 32 results

3. EBSCO
   = 116 results

- Subject filters of "mental health", "recovery", "mental disorders" and "mental health services"
  = 35 results

4. PubMed
   = 24 results

- Document type – articles full-text
  = 8 results

5. Web of Science
   = 70 results

- Refined to "articles" = 66 results
- Searched within results for "recovery" = 38 results
- Articles with access
  = 16 results

6. Final stage

   - Inclusion/exclusion criteria applied by both researchers to results. Cross-referencing used also.

- Agreed that highest-priority articles should only be included in the final list from the five databases. Articles that discuss all of the following four concepts: service user + recovery + mental health + co-production
- From five databases

= 4 final results that met criteria

Note: Appendix detailing search strings and deduction process as per Higgins and Pinkerton (1998).

Corresponding author

Michael John Norton can be contacted at: nortonmichael92@gmail.com