

**From the rhetoric to the real: A critical review of how the concepts of recovery and social inclusion may inform mental health nurse advanced level curricula – the eMenthe project**

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## **Abstract**

### ***Objectives***

This critical review addresses the question of how the concepts of recovery and social inclusion may inform mental health nurse education curricula at Master's level in order to bring about significant and positive change to practice.

### ***Design***

This is a literature-based critical review incorporating a modified rapid review method. It has been said that if done well, this approach can be highly relevant to health care studies and social interventions, and has substantial claims to be as rigorous and enlightening as other, more conventional approaches to literature (Rolfe, 2008).

### ***Data sources***

In this review, we have accessed contemporary literature directly related to the concepts of recovery and social inclusion in mental health.

### ***Review methods***

We have firstly surveyed the international literature directly related to the concepts of recovery and social inclusion in mental health and used the concept of emotional intelligence to help consider educational outcomes in terms of the required knowledge, skills and attitudes needed to promote these values-based approaches in practice.

### ***Results***

A number of themes have been identified that lend themselves to educational application. International frameworks exist that provide some basis for the developments of recovery and social inclusion approaches in mental health practice, however the review identifies specific areas for future development.

### ***Conclusions***

This is the first article that attempts to scope the knowledge, attitudes and skills required to deliver education for Master's level mental health nurses

based upon the principles of recovery and social inclusion. Emotional intelligence theory may help to identify desired outcomes especially in terms of attitudinal development to promote the philosophy of recovery and social inclusive approaches in advanced practice. Whilst recovery is becoming enshrined in policy, there is a need in higher education to ensure that mental health nurse leaders are able to discern the difference between the rhetoric and the reality.

## **Introduction**

The context for this review is a European-funded educational project, developing master's level materials for mental health nurse education the eMenthe project. It has been asserted that mental health nurse education needs to address the gap between theory and practice when it comes to recovery principles (Cleary and Dowling, 2009, Gale and Marshall-Lucette, 2012) and our project seeks to address this issue. In this review therefore, we pose the question of: *How might the concepts of recovery and social inclusion inform mental health nurse Masters level curricula?* In answering this question we first define the concepts and use educational theory (notably the concept of emotional intelligence) to inform our inquiry. The approach we are using is a literature-based critical review based upon the findings of a rapid review of the relevant literature. It has been said that if done well, the critical review can be highly relevant to health care studies and social interventions, and has substantial claims to be as rigorous and enlightening as other, more conventional approaches to literature (Rolfe, 2008). Our inquiry is guided by theory and is not an attempt at systematically reviewing the literature. That said we have firstly conducted a rapid review (Khangura et al., 2012) and taken into account the up-to-date international literature on recovery and social inclusion that has relevance to this inquiry.

## **Defining the topics**

Firstly we define the core concepts to the review: recovery and social inclusion and briefly describe emotional intelligence theory in relation to nurse education as an analytic lens for our inquiry.

### **Recovery**

Recovery in mental health is not an easy concept to define or articulate. Some early definitions of the concept were offered by Deegan (1988) and Anthony (1993). Deegan (1988) sees recovery as a process where people acknowledge being socially disabled by their mental health problems and recover a new sense of self. Anthony (1993, p.527) developed these ideas further by contending that “...*recovery involved the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness*”. Warner (2004) identified two uses of the word recovery: the first being the loss of symptoms and a return to a state of health similar to that before the illness (complete recovery) and the second he regards as a ‘social’ recovery (further elaborated upon in our definition of social inclusion). Davidson et al. (2005) argue that different forms of recovery can exist within the context of an individual’s life. Others such as Williams et al., (2012) differentiates between clinical recovery and personal recovery. Some (e.g. Repper and Perkins, 2003, Higgins and McBennett) reject universal definitions and prefer those that are defined by the individual. In their over-arching mental health policy framework, the UK government cites Anthony’s (1993) work in their definition:

*“This term has developed a specific meaning in mental health that is not the same as, although it is related to, clinical recovery. It has been defined as: ‘A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life’.”*  
(Department of Health, 2011)

In this review, we broadly accept the above definition.

## ***Social Inclusion***

The concept of social inclusion in Europe varies to what may be understood in other parts of the world. For example, in North America, the term is largely applied to people from Afro-Caribbean backgrounds. In Europe, notably between 1970s and the 1990s theorists and politicians promoted the concept of social inclusion and exclusion and these concepts became enshrined in European policies. Emphasis was placed upon poverty and deprivation which prevent people from fulfilling the obligations attached to their social roles. The *Joint Inclusion Report* became adopted by the European Commission in 2004 (European Union, 2004). The European conceptualisation of exclusion implies that there has been a breach of social justice (Silver and Miller, 2003). In recent years social exclusion has become strongly associated with inequality (Marmot et al., 2010, Wilkinson and Pickett, 2010) and that it is not only poverty that causes exclusion, but poverty in relation to unattainable wealth in societies i.e. economic inequality. This is supported by Friedli's report for the World Health Organisation (Friedli, 2009) where the author observes that it is difficult to differentiate between the causes and effects of mental health problems and social exclusion.

One often cited definition of social inclusion for people with mental health problems is:

*'A virtuous circle of improved rights of access to the social and economic world, new opportunities, recovery of status and meaning, and reduced impact of disability. Key issues will be availability of a range of opportunities that users can choose to pursue, with support and adjustment where necessary'* (Sayce, 2001, p.122)

Thus, European definitions for social inclusion and exclusion are less contested than international definitions of recovery.

## **Method**

This review comprised two stages: once the question was defined, a rapid review (Khangura et al., 2012) was conducted on the key concepts of recovery and social inclusion in mental health. Secondly, we employed a critical review approach as presented by Edgley et al., (2014). There is no recognised or traditional structure for a critical review and the approach is flexible enough to allow the direction of the study to be formed by the results of the analysis (Grant and Booth, 2009). Our starting point had been addressing the question: *'How might the concepts of recovery and social inclusion inform mental health nurse Masters level curricula?'* We firstly needed to define recovery and social inclusion but also what constitutes Masters level knowledge, understanding, skills, and practice in contrast with pre-registration nurse education.

The rapid review process sought to identify existing key literature reviews on the concepts of recovery and social inclusion in mental health and included articles that were considered to be contributing to defining the recovery concept. For this we used the key words: *recovery, social inclusion, mental health, review* and applied these search terms to a number of databases that included MEDLINE, CINAHL, EMBASE, ASSIA, PSYCHINFO, Web of Science and the Web of Knowledge and Google Scholar. A good number of articles included the word 'recovery' but were not relevant to the inquiry as they talked more about clinical recovery, or used the phrase as clichéd term and did not contribute to understanding of the concept. Eventually approximately 200 papers were included in the study. Lal and Aadair (2014) argue that rapid reviews may not be as exhaustive as systematic reviews, but they can still produce valid conclusions and provide in-depth synthesis on a given topic. Our research team comprised academics from five European countries and whilst the majority of published articles were in the English language, we were also able to review articles in a number of European languages.

A significant paper by Leamy et al., (2011) enabled us to systematically sort the papers into pre-identified themes. Leamy et al, (2011) conducted a comprehensive narrative synthesis of the literature on personal recovery in order to establish a conceptual framework ("CHIME" see Table 2). Once we

attributed approximately 50 articles into the CHIME framework we also identified 14 other themes and these are contained in Table 3. Once these themes were identified we then conducted the second stage of our review, which was the critical review informed by the findings of the rapid review.

Once we examined the relevant literature on recovery and social inclusion, we concluded that because these concepts were largely concerning human endeavour such as hopes, beliefs and empowerment, advanced learning would include emotional as well as intellectual learning. The research team then considered key theories in nurse educational literature that might be used as a theoretical lens through which to consider how the concepts of recovery and social inclusion may inform mental health nurse advanced level curricula. The educational theory of emotional intelligence was then decided upon as a theoretical framework through which we could address our question as it is a theory that is relevant to the development of emotions, self-awareness and values consistent with concepts such as hope, beliefs and so on.

The following section identifies relevant mental health educational frameworks and also defines Masters level outcomes before we explore the conceptual underpinning of our theoretical framework.

### **Contemporary educational frameworks to inform mental health education**

Traditional nurse education theorists such as: Benner (1983), Bondy (1983), Carper (1978), Steinaker and Bell (1979), have contributed much to a common understanding of knowledge and skills attainment, but it is only fairly recently that specific attention has been given to a detailed focus upon mental health nurse education. One of the most significant developments in mental health education has been the "*Ten Essential Shared Capabilities for Mental Health Practice*" (10 ESCs) (Department of Health, 2004) in the UK.

The framework was produced as a joint project between the National Institute for Mental Health England and the Sainsbury Centre for Mental Health. It was derived from focus groups with experts and stakeholders and was therefore co-produced by service providers, academics, service users and carers and was intended to provide guidance for best practice in mental health training and education for the entire mental health workforce. The 10 ESCs can be found in the left-hand column in Table 1. The only other country to have developed anything similar is New Zealand with the "*Recovery Competencies for New Zealand Mental Health Workers*" which was produced for the Mental Health Commission in 2001. Similarly there are 10 competencies and these are also found in Table 1.

In preparation for degree level nurse curricula and significantly for mental health nurse education, The Nursing and Midwifery Council (2010) in the UK, appears to enshrine much of the 10 ESCs in their "*Standards of Competence for Registered Nurses*", especially in the section specifically relating to mental health nurse competencies. Table 1 illustrates this and maps the ESCs against the New Zealand competencies:

**TABLE 1 HERE**

There is limited critical appraisal within the literature of the implementation of the 10 ESCs and since the change of government in the UK in 2010; there has been no obvious statutory reference to the framework. There is also no evidence of research or critical appraisal in the academic literature of the Recovery Competencies for New Zealand Mental Health Workers (Mental Health Commission, 2001). Arguably, the framework has influenced the development of the "*Standards of Competence for Registered Nurses*", especially for mental health nurses (Nursing and Midwifery Council, 2010). Furthermore, various professions outside of nursing have identified its usefulness e.g. Occupational therapy (Pettican and Bryant, 2007), Psychiatry (Dogra and Karim, 2005, Lester and Gask, 2006) and Psychologists (Harper et al., 2007). However, there is little in the literature that may directly apply concepts of recovery and social inclusion to mental health nurse education.



## ***Masters level education***

The Universities in each European country may have their own criteria that define the expected outcomes from Master's level education. Because this review is serving a European project, it will therefore employ the criteria found in the European Qualifications Framework (EQF). This acts as "*a translation device to make national qualifications more readable across Europe, promoting workers' and learners' mobility between countries and facilitating their lifelong learning.*" (EQF, 2015:4). In this document Masters Level is referred to as level 7 and identifies the following expected outcomes:

### ***Knowledge***

This is defined as the outcome of the assimilation of information through learning including facts, principles, theories and practices.

### ***Skills***

In the EQF context, skills are seen as the ability to apply knowledge and use know-how to complete tasks and solve problems.

### ***Competence***

Competence is described in terms of being able to use the knowledge and skills with responsibility and autonomy.

Our study therefore requires us to consider what would constitute a Masters graduate when it comes to knowledge, skills and attitudes related to recovery and social inclusion. It is envisaged that students studying at Masters level will already have studied at Bachelors level and gained experience working in mental health settings. Assessment therefore would need to be set against criteria to match level 7 and students would need to be able to use and apply the knowledge and skills in a competent and advanced manner to differentiate from level 6 (undergraduate).

We have chosen to focus upon the concept of emotional intelligence because recovery and social inclusion principles are values-based and as such, have an emotional component. We have commenced therefore with the premise that a pedagogy that seeks to nurture values needs to be aimed as much at the emotional level as the cognitive.

### **The concept of emotional intelligence in relation to nurse education**

Intelligence is often associated with factual knowledge related to the natural sciences. Emotional intelligence (EI) however is more directly related to competency in the emotional realm either inwardly (self-awareness) and thus affecting decision-making and coping and so on, or in relation to the understanding of others (Jordan and Troth, 2002, Salovey et al., 1990). Freshwater and Stickley (2004) argued that nurse education has drifted towards an essentialist focus becoming too aligned to positivist outcomes. They propose an education that is transformatory in essence that is based upon reflective practice, engagement through the arts and humanities and an education that listens to the voices of those who use health services in order to engender emotional engagement and learning amongst students. This is reinforced by Akerjordet and Severinsson, (2007) who highlight that in nursing practice "EI could be integrated into nursing education in a more realistic and appropriate way by means of transformatory learning with focus both on emotional and rational development processes." (Akerjordet and Severinsson, 2007, p. 1410). Bulmer Smith et al., (2009) assert that in order for patient care to be improved EI needs to become explicit in nurse education.

The recovery agenda has service user narratives at its heart (Lapsley et al., 2002). Furthermore, it is argued that if students engage with such narratives, this will stimulate EI (Freshwater and Stickley, 2004; McKeown et al., 2010). Masters level education that is recovery-orientated and seeks to promote emotional intelligence, would therefore consider service user narratives to be central to learning. Recovery theory demands emotional intelligence from mental health nurses in order to understand and

demonstrate concepts such as hope, meaning to life and empowerment (Leamy et al., 2011).

## **Discussion**

This study is addressing the question: *how might the concepts of recovery and social inclusion inform mental health nurse Master's level curricula?*

Having defined core concepts for this study, the remainder of this article will attempt to answer this question. The structure of the discussion considers the core knowledge, attitudes and skills (Bloom, 1956) that may be extracted from the recovery and social inclusion literature and postulates how these may be both learnt and taught at Master's level through the development of an emotionally intelligent curriculum.

### ***Knowledge of recovery and social inclusion for life-long learning***

The knowledge-base for concepts of recovery and social inclusion has grown rapidly in recent years. The seminal work "*Social Inclusion and Recovery*" (Repper and Perkins, 2003) was one of the first books to bring the two concepts together. With this in mind, we have limited our conceptual review to published peer-reviewed academic literature since this date. Stickley and Wright (2011) observed that in their systematic review of the British literature from January 2006 to December 2009 there are very few research papers focusing specifically on the recovery and mental health concept, furthermore, in their systematic review of the literature directly related to mental health and social inclusion, Wright and Stickley (2013), drew similar conclusions. However conducting this current review, we discovered that in more recent years research directly related to recovery has escalated, especially in relation to understanding the concept, attempting to measure this and suggestions for service development (Borg and Davidson, 2008; Leamy et al., 2011, Slade, 2012, Williams et al., 2012, Kartalova-O'Doherty et al., 2012; Gilbert et al., 2013, Shanks et al., 2013, Daley et al., 2013, Leamy et al., 2014). One significant contribution to the knowledge-base of the recovery concept is by Leamy et al., (2011) who conducted a narrative

synthesis of the literature on personal recovery in order to establish a conceptual framework. The framework comprises 13 characteristics, five processes and five stages. The five over-arching themes (processes) are: connectedness, hope, identity, meaning to life and empowerment (CHIME). The framework has been subject to subsequent validation (Bird et al., 2014). In terms of advancing the knowledge-base of recovery, the five themes may serve the advanced mental health nursing student well. If the connectedness theme is expanded to incorporate principles of social inclusion, then further in-depth study could be directed by accessing contemporary, as well as more foundational theories as follows in Table 2:

**TABLE 2 HERE**

In addition to the CHIME framework, we have also identified from the recent international literature various themes that can also be considered essential to understanding recovery and social inclusion at Master's level. These are listed in Table 3. For the benefit of this critical review, we are relying upon the CHIME framework for personal definitions of recovery and these themes will not be repeated in Table 3. In other words, the findings illustrated in Table 3 complement the CHIME framework.

**TABLE 3 HERE**

Students at Master's level study will not only need to be aware of the relevant theories and key concepts pertaining to the topic of recovery and social inclusion however, they will also need knowledge of the critical debates surrounding the subject and to be able to critically appraise these. Furthermore, there are foundational theories that may be considered essential to understanding some of the identified themes. Examples might be: social belonging (Tajfel, 1982, Tajfel, 2010); theories of power (Nietzsche, 1966, Foucault, 1980, Stewart, 2001, Thompson, 2006); strengths and other elements of humanistic and positive psychology: (Gandi and Wai, 2010, Maslow, 1973, Snyder, 1994, Frankl, 2004, Carr, 2011, Rapp and Goscha, 2004); and identity and stigma (Erikson, 1980, Goffman, 1959, Goffman, 1963, Link and Phelan, 2001).

One central debate around recovery relates to its definition; is there conflict between a clinical definition (used by professionals) and a personal definition (that is subjectively determined)? Furthermore, as the Mind (2008) report articulates, if it is subjectively determined then the legitimacy of services to provide “recovery” is undermined especially in light of its coercive agenda to protect the public. Professionals are often regarded as a part of the problem rather than part of the solution (Pilgrim, 2008). Likewise, with the concept of social inclusion in mental health there are strong social forces at work that may prevent meaningful inclusion such as inequality (Wilkinson, 2005, Marmot et al., 2010, Wilkinson and Pickett, 2010).

If professionals are intent upon delivering a service attuned to recovery and social principles, as Ramon et al., (2007) assert they need a complete change of attitude away from one that views people in a pessimistic and negative light towards one that is positive and hopeful. The next section addresses the area of attitudes and how these can be influence in advanced mental health education.

### ***Attitudes for recovery and social inclusion for Master’s level studies***

It is in the area of attitudes that the concept of emotional intelligence may have much to contribute to the learning of recovery and social inclusion principles and practice. Primarily, a recovery approach views the person differently to the way in which psychiatry has historically viewed the “patient” (Foucault, 1973). A recovery approach demands a more humane understanding of the human condition and is inevitably at odds with the medical model which has historically treated people as diseased or disordered and in need of clinical recovery. Recovery is essentially based upon humanistic philosophy (Spandler and Stickley, 2011, Stickley and Wright, 2011, Wharne et al., 2012) and at the heart of this philosophy is a firm belief in the potential of all humans. Recovery approaches therefore demand a respect for the uniqueness of the individual journey and treat people with dignity, exercising empathy and maintaining an unconditional positive attitude towards the person. A recovery-based relationship therefore is one

that is characterised more by listening and understanding than by coercing and treating. However, working with people who are at times seriously disturbed or experiencing feelings of extreme desperation, nurses need well-developed self-awareness in order to cope and maintain these values. Emotional intelligence theory applied to mental health nursing may recommend transformational learning (Freshwater and Stickley, 2004) to accommodate this attitudinal change in attitudes from perceiving the *person-as-patient* to the *person-as-person*. Transformatory learning theory is widely attributed to Jack Mezirow who espoused transformation in three domains: the psychological (related to self-development, growth and change), convictional (change in beliefs and values), and behavioural (how these personal changes affect practice) (Mezirow, 1997, Mezirow, 1991, Mezirow, 1978, Mezirow, 1975). Examples of how this may be accomplished are already established in the literature through for example, service user-teaching/training and peer-support. Furthermore, narratives have featured significantly in the international recovery literature and the use of narratives is becoming wide-spread as triggers for reflection and insight into the construction of personal identity (e.g. Pack, 2013). The second area for the potential use of narrative to promote emotional intelligence might be to challenge students' unconscious stigmatising attitudes (O'Reilly et al., 2012).

### ***Skills for recovery and social inclusion for life-long learning***

There are many skills that can be identified from the knowledge-base highlighted above. These would include: how to work collaboratively, power-sharing, promoting shared decision-making and self-management (Ammeraal et al., 2013, Fieldhouse and Onyett, 2012, Gandhi and Wai, 2010, Hill et al., 2010, Iancu et al., 2013, Mayes, 2011, McEvoy et al., 2012, Tew et al., 2012, Todd et al., 2012, Van der Stel, 2013); and positive risk-taking (Bird et al., 2014, Heller, 2014, Kelly et al., 2009, Robertson and Collinson, 2011, Stickley and Felton, 2006, Tickle et al., 2014). In order to promote socially inclusive outcomes, various skills can be identified from the literature: e.g. mapping community services (Stickley, 2005); counteracting social isolation (Borg and Davidson, 2008, Bradstreet and McBrierty, 2012, Dorer et al.,

2009, Edgley et al., 2012, Fieldhouse, 2012b, Killaspy et al., 2014, Tew et al., 2012, Tooth et al., 2003); strategies for overcoming stigma within communities as well as amongst professionals (Evans-Lacko et al., 2014, Killaspy et al., 2014, Bertram and Stickley, 2005, Felton et al., 2009, Martyn, 2002, Mezey et al., 2010, Quinn et al., 2011).

The study of positive psychology may also help the mental health nursing student at master's level. Themes such as hope and strengths-based approaches are common to recovery in mental health and also positive psychology. Furthermore, there are new approaches in the therapies that are also consistent with the recovery ethos such as motivational interviewing, compassion-focused therapy, strengths interviewing and coaching skills.

## **Conclusion**

In terms of relating the findings of this review to Bloom's taxonomy (Bloom, 1956), we conclude that cognitive, affective and psychomotor development are each important to advanced level mental health education and the concepts of recovery and social inclusion may demand development of each as identified in this review. Emotional intelligence may help to identify desired outcomes especially in terms of attitudinal development to promote the philosophy of recovery and social inclusive approaches in advanced practice. Whilst in western countries recovery is becoming enshrined in policy frameworks, there is a need in higher education to ensure that current and future mental health nurse leaders are able to discern the difference between the rhetoric and the reality. This review has identified areas of opportunity for educational development, it does not however provide the pedagogical solutions; this will comprise the next stage of the European project alluded to in the first paragraph.

## **Acknowledgements**

This project has been funded with support from the European Commission/ Life-long learning program. This publication reflects the views only of the authors, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

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**Table 1: Identifying commonalities between the 10 ESCs, the Recovery Competencies for New Zealand Mental Health Workers and the NMC Standards of Competence for Registered Nurses (Nursing and Midwifery Council, 2010).**

ESC	Recovery Competencies	NMC
Working in partnership	<p>acknowledges the different cultures of Aotearoa/NZ and knows how to provide a service in partnership with them</p> <p>knowledge of the service user movement and is able to support their participation in services</p> <p>knowledge of family/whanau perspectives and is able to support their participation in services</p>	<p>All nurses must understand the roles and responsibilities of other health and social care professionals, and seek to work with them collaboratively for the benefit of all who need care.</p> <p>They must make... decisions, in partnership with others.</p> <p>They must seek to maximise service user involvement and</p>

		therapeutic engagement...
Respecting Diversity	understands and accommodates the diverse views on mental illness, treatments, services	All nurses must practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions... and acknowledges diversity.
Practising ethically	understands and actively protects service users' rights	All nurses must practise with confidence according to... recognised ethical and legal frameworks
Challenging Inequality	understands discrimination and social exclusion	Mental health nurses must challenge the inequalities and discrimination that may arise from or contribute to mental health problems.
Promoting Recovery,	understands recovery principles and experiences	Mental health nurses must provide... recovery focused practice
Identifying People's Needs and Strengths	recognises and supports the personal resourcefulness of people with mental illness	...empower choices that promote self-care and safety.
Providing Service User Centred Care	self-awareness and skills to communicate respectfully and develop good relationships with service users	Mental health nurses must... provide person-centred and recovery-focused practice
Making a difference	comprehensive knowledge of community services and resources and	All nurses must use up-to-date knowledge and evidence to assess, plan, deliver



	actively supports service users to use them	and evaluate care, communicate findings, influence change and promote health and best practice
Promoting safety and positive risk-taking	This aspect of the ESC is included in the competence on Recovery	...using interventions that balance the need for safety with positive risk-taking.
Personal development and learning	This aspect of the ESC is included within the competency on self-awareness	All nurses must be responsible and accountable for keeping their knowledge and skills up to date through continuing professional development.

**TABLE 2: KNOWLEDGE FOR RECOVERY AND SOCIAL INCLUSION**

<b>Theme (CHIME)</b>	<b>Relevant literature</b>
Connectedness including: social belonging, social capital, social inclusion, inequality	Boardman (2010), Borg and Kristiansen (2008), Day (2013), Davidson and Roe (2007), Friedli (2009), Hamer et al. (2014), Kartalova-O'Doherty and Doherty (2010), Marmot et al. (2010), McKenzie and Harpham (2006), Phillipson et al. (2004), Tew et al. (2012), Whitley et al. (2008), Wilkinson (2005), Wilkinson and Pickett (2010), Field (2008), Kal (2010), Kal et al. (2012)
Hope, including: human potential, positive psychology, strengths	Adams (2010), Edgley et al. (2012), Hobbs and Baker (2012), Kogstad et al. (2011), Kartalova-O'Doherty et al., (2012), Sapouna and Pamer (2014), Spandler and Stickley (2011)
Identity, including social	Benwell and Stokoe (2006), Boevink (2006b),

identity	Bradstreet and McBrierty (2012), Daley et al. (2013), Heron et al. (2012), Jenkins and Carpenter-Song (2008), Kartalova-O'Doherty and Doherty (2010), Kerr et al. (2013), Tooth et al. (2003), Yates et al. (2012), Kal (2010), Kal et al. (2012), Tan et al. (2014)
Meaning to life, including: theology, spirituality and human philosophy	Barber et al. (2012), Kogstad et al. (2011), Cook (2013), Frankl (2004), Miller-Perrin and Krumrei-Mancuso (2014)
Empowerment	Daley et al. (2013), Ramon et al. (2011), Repper and Carter (2011)

**TABLE 3: 14 FURTHER KEY CONCEPTS IN RECOVERY AND SOCIAL INCLUSION**

<b>Key Concepts</b>	<b>Relevant literature</b>
Narrative and recovery as a journey or a process; evidence-based medicine versus narrative theory	Barker and Buchanan-Barker (2010), Buchanan-Barker and Barker (2008), Castillo et al. (2013), Clements (2012), Collier (2010), Kerr et al. (2013), Ramon et al. (2011), Salkeld et al. (2013)
Theory of change management and positive adaptation, coping theory, transformational change	Deegan (2002), Eriksen et al. (2013), Provencher (2007), Todd et al. (2012), Tooth et al. (2003)

of services	
Participatory democracy, taking control, participatory models, shared decision-making, self-help and self-management	Ammeraal et al. (2013), Fieldhouse and Onyett (2012), Gandi and Wai (2010), Hill et al. (2010), Iancu et al. (2013), Martyn (2002), Mayes (2011), McEvoy et al. (2012), Tew et al. (2012), Todd et al. (2012), Van der Stel (2013)
Poverty, sick-role and social model of disability	Benbow et al. (2014), Clifton et al. (2013), Fieldhouse and Onyett (2012), Pilgrim (2008), Stickley (2005)
Diagnosis, labelling, discrimination and stigma (including self-stigma)	Evans-Lacko et al. (2014), Killaspy et al. (2014), Bertram and Stickley (2005), Felton (2014), Felton et al. (2009), Mezey et al. (2010), Quinn et al. (2011)
Social movements in area of service such as: user engagement; patient as expert, peer-support, self-help groups; hearing voices movement and human rights	Ammeraal et al. (2013), Boevink (2006a), Byrne et al. (2013), Clements (2012), Cook et al. (2009), Forrest (2014), Hungerford (2014), Kantartzis et al. (2012), Montgomery et al. (2012), Pistrang et al. (2008), Repper and Carter (2011), Schneebeli et al. (2010), Spandler and Stickley (2011), Tew et al. (2012)
Critical psychiatry and anti medical model	Barker and Buchanan-Barker (2011), Marrington-Mir and Rimmer (2006), Mind (2008)
Friendship, community development and engagement with	Borg and Davidson (2008), Bradstreet and McBrierty (2012), Dorer et al. (2009), Edgley et al. (2012), Fieldhouse (2012b), Killaspy et al. (2014),

community.	Thornicroft (2011), Tooth et al. (2003)
Engagement with leisure, culture, arts and creativity	Carless and Douglas (2008), Colbert et al. (2013), Hacking et al. (2008), Kal (2010), Kal et al. (2012), King et al. (2013), Makin and Gask (2012), Margrove et al. (2013), Sapouna and Pamer (2014), Spandler and Stickley (2011), Spandler et al. (2007), Parr et al. (2004), Secker et al. (2011), Quinn et al. (2011)
Tools to measure recovery and/or social inclusion process and outcomes	Ayres et al. (2014), Barber et al. (2012), Baumgartner and Burns (2014), Bekas (2013), Chiba et al. (2010), Clifton et al. (2013), Coombs et al. (2013), Dickens et al. (2012), Doyle et al. (2012), Fitzgerald (2010), Gandi and Wai (2010), Gordon and Ellis (2013), Green et al. (2011), Gudjonsson et al. (2010), Hacking et al. (2006), Jones et al. (2012), Jones et al. (2013), Killaspy et al. (2012), Law et al. (2012), Lloyd et al. (2008), Mezey et al. (2013), Secker et al. (2009), Sklar et al. (2013), Slade et al. (2011), Stickley and Shaw (2006), Weeks et al. (2011), Williams et al. (2012)
Risk and therapeutic risk-taking	Bird et al. (2014), Heller (2014), Kelly et al. (2009), Robertson and Collinson (2011), Stickley and Felton (2006), Tickle et al. (2014), Todd et al. (2012), Young (2011)
Vocation, occupation, education and training	Ammeraal et al. (2013), Borg and Kristiansen (2008), Cook et al. (2009), De Heer-Wunderink et al. (2012), Doughty et al. (2008), Fieldhouse (2012a), Fowler et al. (2009), Gilbert et al. (2013), Heasman and Atwal (2004), Iancu et al. (2013), Kantartzis et al. (2012), Keogh et al.

	(2014), Killaspy et al. (2014), Nieminen et al. (2013), Ramon et al. (2011), Ramon et al. (2009), Smyth et al. (2011), Hammer (2000), Parr (2007), Salkeld et al. (2013), Svanberg et al. (2010)
Service Development	Adams (2010), Ayres et al. (2014), Baker et al. (2014), Barber et al. (2012), Barker and Buchanan-Barker (2010), Bekas (2013), Bradstreet and McBrierty (2012), Castillo et al. (2013), Daley et al. (2013), Dickens et al. (2012), Doyle et al. (2012), Fitzgerald (2010), Gale and Marshall-Lucette (2012), Gilbert et al. (2013), Green et al. (2011), Gudjonsson et al. (2010), Heron et al. (2012), Hill et al. (2010), Hobbs and Baker (2012), Jones et al. (2012), Katsakou et al. (2012), Killaspy et al. (2012), Law et al. (2012), Leamy et al. (2011), Leamy et al. (2014), Marland et al. (2011), McGrath et al. (2013), Mezey et al. (2010), Salkeld et al. (2013), Slade et al. (2011), Slade et al. (2014), Smith-Merry et al. (2011), Torrey et al. (2005), Turton et al. (2010), Turton et al. (2011)
Training and education for students and staff	Byrne et al. (2013), Cook et al. (2009), Doughty et al. (2008), Gudjonsson et al. (2010), Keogh et al. (2014), Salkeld et al. (2013), Schneebeil et al. (2010), Stacey and Stickley (2012)