'We're Still in There'—Consumer Voices on Mental Health Inpatient Care: Social Work Research Highlighting Lessons for Recovery Practice

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Abstract

This paper reports on research undertaken in an acute inpatient mental health facility in rural Australia to explore the lived experience of inpatient care. Conceptualised within a recovery framework that emphasises the biopsychosocial approach acknowledging consumers' lived experiences alongside clinical perspectives, this study contributes to addressing a gap in the literature about what consumers experience as being most important to their recovery during an episode of inpatient care. Traditionally, mental health service delivery has been weighted towards clinical recovery with a biomedical approach dominating. This is especially so in an inpatient setting. In this qualitative study, the personal and social components of recovery emerge as critical factors for consumers even in an acute phase of care indicating a need to redress the imbalance. Eight in-depth semi-structured interviews were conducted with consumers during their stay in the inpatient facility. Drawing on a hermeneutic phenomenological analysis and the use of NVivo, three themes emerged: the importance of listening, facilitating peer support and the inclusion of families. All three themes resonate with core social work practice suggesting social workers have a critical role to play in the transformation of mental health services to reflect the recovery paradigm.

Keywords: Recovery-oriented practice, biopsychosocial, mental health, inpatient care, social work practice, social work, biomedical model

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Introduction

The rise of the consumer-led recovery movement in mental health based on personal narratives of lived experience has led to a more complex approach to mental health service delivery than that offered by the traditional biomedical model. Through the lens of the biomedical model, recovery has traditionally been viewed as a linear process involving the identification of clinical symptoms leading to a diagnosis that in turn informs appropriate treatment. Practice based on this model is deficit-focused, top-down and expert-driven. Beginning as a challenge to the biomedical model, contemporary approaches to mental health service delivery view the consumer as expert by experience and are founded on meaning-making, hope and strengths. These approaches to care are not oppositional. Multifaceted definitions of recovery have emerged in recent years in an attempt to fully encompass the complex phenomenon of recovery from a mental illness. The quest to shift service delivery to a more nuanced recovery approach including making room for consumer-led perspectives implies major changes to traditional service delivery. These changes are also reflected in formal policy documents internationally.

In Australia, key documents mandate the move to recovery principles across mental health service delivery. These include the *National Mental Health Plan 2009–2014* (Australian Health Ministers, 2009), the *National Standards for Mental Health Services* (Department of Health and Ageing, 2010) and the *National Practice Standards for the Mental Health Workforce* (Australian Government Department of Health, 2013). It is expected that principles of recovery-oriented practice within these guiding documents will compel a change in practice from the traditional biomedical approach to one that is inclusive, collaborative and values an epistemology derived from lived experience. For mental health professionals at the front line of service delivery in an inpatient setting, working within these recovery principles requires a major shift in attitude and practice as the principles can challenge the biomedical tenets in which most mental health professionals have been trained.

A strong alignment exists between the values and principles underpinning social work and those of the recovery movement. This example of social work research evidences the significant role social work can play in ensuring a recovery focus in this challenging environment.

The concept of recovery in mental health

The task of defining recovery in mental health has been contested for many years. Only a few authors venture to present their own definitions of recovery (see, e.g. Andresen *et al.*, 2003; Crowe *et al.*, 2006; Thornton and Lucas, 2011).

Many authors, such as Gandi and Wai (2010), Happell (2008) and Kogstad *et al.* (2011), prefer the pioneering definitions from Anthony (1993) and Deegan (1988). Slade *et al.* (2008) refer to a 'two-part' definition of recovery differentiating clinical recovery from personal recovery. Clinical recovery is described as an absence of symptoms and functional impairment which is aligned with the biomedical model and which can be reasonably measured. Personal recovery is a uniquely individual narrative and involves gaining new meaning and purpose in life even in the presence of ongoing symptoms. Barber (2012) proposes three ways of conceptualising recovery adding 'illness management' to the notions of clinical and personal recovery as outlined above. Illness management involves symptom control and monitoring of the illness by both doctor and patient and is compared to the type of recovery applied to chronic physical conditions such as diabetes and hypertension. While the three-way definition is useful for wider purposes, for this study, Slade *et al.*'s (2008) two-part definition is adopted.

Many authors have isolated key themes that are consistent across the multiple interpretations of personal recovery. Slade (2009*b*) identifies the development of a positive self-identity, meaning-making, self-management and the development of valued social roles as the key tasks for personal recovery. Based on a wider review, Tew *et al.* (2012) isolate three concepts central to recovery—empowerment, connectedness and the rebuilding of positive identities. In Australia, the *National Standards for Mental Health Services* (Department of Health and Ageing, 2010) include principles of recovery-oriented mental health care such as uniqueness of the individual, real choices, partnership and communication.

Slade (2009*a*) provides a table contrasting the traditional approach (which is based on the principles of the biomedical model and clinical recovery) with the personal recovery approach. He states that it is generally acknowledged that 'most mental health services are currently organised to meet the goal of clinical recovery' (Slade, 2009*a*, p. 4) addressing only one half of the two-part definition of recovery. Slade notes in the final section of this document that the inclusion of recovery principles in mental health service delivery requires 'fundamental transformation' and 'a paradigm shift' relocating the patient's perspective from a traditionally peripheral position to the central core (Slade, 2009*a*, p. 26). The biomedical model with its emphasis on clinical recovery has historically dominated over the psycho and social aspects of recovery. The existing epistemological tension is well explained by Slade (2009*b*) who proposes constructivism as 'a more helpful epistemological basis' for understanding recovery (p. 54). Bloom (2005) questions the displacement of the term 'biopsychosocial' in recent years—a term first proposed by Engel (1977) to counter the reductionist notions inherent in biomedicine. 'Biopsychosocial' may best describe the point of fusion for recovery definitions.

According to Parker (2014), ensuring that different 'models of madness' are complementary is not a simple matter. He states that the distinctive ontology and epistemology of different models significantly impact on matters of

policy, treatment and social justice. Parker identifies the main models in mental health practice as cognitive behaviour therapy, systemic, psychoanalytic and medical, and discusses the challenges thrown to these models by 'madness itself'—the voices of those who have experienced the phenomenon. He states that 'social justice is only possible when the expertise of those who are theorized about begin to have their own voices heard in all their complexity and contradictoriness' (Parker, 2014, p. 32).

Social work contributions to the recovery discussion

For mental health social workers, the principles of recovery-oriented practice are a breath of fresh air lending legitimacy and credibility to social work values and principles that clearly mirror the recovery focus. Self-determination, empowerment, collaboration, strengths focus, hope-giving and human rights are as much embedded in social work codes of ethics as they are present in discussions of recovery-oriented practice. This alignment has been noted elsewhere (Hyde *et al.*, 2014; Loumpa, 2012) and is clearly seen when the language of recovery and the language of social work values and principles are placed side by side. This comparison is reproduced here in Table 1 (Hyde *et al.*, 2014).

Despite this strong alignment between social work values and principles and those of the recovery movement, the social work voice as a proponent of change in the mental health field is remarkably absent (Hyde *et al.*, 2014; Ramon, 2009; Loumpa, 2012). Social work occupies a marginalised position within those settings dominated by a biomedical discourse such as an

Table 1 Comparison of social work and recovery principles (Hyde *et al.*, 2014)

Social work	Recovery approach
Self-determination	Self-determination
Empowerment	Empowerment
Acceptance and uniqueness of individuals	Personal meaning, expert by experience
Collaboration and participation	Collaborative relationships
Identifying and developing strengths	Strengths
Respect for inherent dignity, worth and autonomy of every person	Self-identity, sense of agency, inherent capacity to live a full and meaningful life of their choosing
Respects the human rights of individuals and groups	Upholding of human rights
Fosters personal/social responsibility	Focusing on strengths and personal responsibility
Hope-giving	Hope and optimism
Reflective awareness as part of professional integrity	Staff to engage in reflective practice
(Compiled from IFS Statement of Ethical Principles (2012, http://ifsw.org/policies/statement-of-ethical-principles/); *Code of Ethics* (AASW, 2010); *AASW Practice Standards for Mental Health Social Workers* (AASW, 2008))	(Compiled from Onken *et al.* (2007); Slade (2009a); Glover (2009); Deegan (1995), Australian Health Ministers' Advisory Council (2013a, 2013b))

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inpatient service. Ramon *et al.* (2009) note that, in the mental health field, social work perceives itself as less powerful than other professions. Morley (2003) criticises social workers in mental health for capitulating unquestioningly to the overpowering influence of the biomedical discourse. Morley entreats social workers in the field of mental health to engage in critical practice to deconstruct the 'accepted truths' of the biomedical model in order to be true to the social justice ethics of the profession. Bell (2012) argues that social work needs to break from the conventional positivist paradigm of the biomedical model to develop its own clear ontological base that better represents social work values including inter-connectedness, equity and situated knowledge. This new ontological base would validate service users' lived experience or epistemic agency which is also a key aim of the recovery movement.

Tew (2013) augments the social work contribution to discussions of recovery-focused mental health practice in his proposal of a new paradigm for mental health social work. He extends the notion of 'social capital' identifying different forms of capital that, together, create 'recovery capital'. This is in recognition of the body of evidence that situates social and cultural factors as central to sustainable recovery from mental health difficulties. These include economic, social, identity and personal (or mental) capital. The identification of factors that assist people to deal with an episode of mental distress goes beyond a narrow clinical response by 'reclaiming aspects of personal and social power' (Tew, 2013, p. 362). Curiously, Tew calls for a paradigm shift for social work practice to include the person 'in their social context' (2013, p. 362), begging the question: 'When did the paradigm shift occur *away* from social context for social work?' Perhaps Tew is saying that mental health social work has lost its way and has compromised its *raison d'être*.

Context: the inpatient setting

The dominance of the biomedical model within mental health is most obvious in an inpatient setting—a predominantly traditional medical setting. Many articles in the literature describe the inpatient environment in exceptionally negative terms. Quirk and Lelliott (2002) referred to life on psychiatric wards in the UK at the time as being 'unremittingly bleak' (p. 344). In a related article, Quirk *et al.* (2004) summarise studies from the seventies to the nineties which described inpatient wards as anxiety-inducing environments where patients are exposed to risks such as loss of personhood, medical disempowerment and violence from other patients. Deegan (1995) refers to the 'myriad of micro-aggressions' that she observed on a daily basis within a hospital ward referring to the practices of mental health staff including take-downs, restraint, seclusion and the forced use of medications. Bartholomew and Kensler (2010) in more recent times comment on state psychiatric hospitals

in the USA as continuing to use methods with an emphasis on custodial measures and the use of medication—characteristics of a biomedical model. The dominance of this model is intensified by the presence of a strong legal discourse determining involuntary admissions. This creates the potential for a powerful partnership in which coercion and control can flourish. The challenges of foregrounding a recovery approach in this setting are formidable.

Conceptual framework for research

The research reported here is viewed from the two-part definition of recovery adapted from Slade *et al.* (2008) that incorporates both clinical and personal recovery—essentially a biopsychosocial perspective. The question being considered is: 'What do consumers experience as being most helpful for recovery during an episode of acute inpatient care in a mental health facility?' The choice of methodology values the lived experience of those encountering the phenomenon of inpatient care. This adheres to both social work and recovery principles in giving voice and central focus to those with expertise grounded in lived experience. Central to the research is a belief that social work has much to contribute towards understanding the phenomenon of mental distress putting the 'psycho' and the 'social' back into a biopsychosocial perspective that recognises the full context in which this phenomenon occurs.

The literature review indicates an absence of consumer voices regarding the experience of inpatient care despite the emphasis on its importance to recovery research. Many authors call for further research in this area (Kogstad *et al.*, 2011; Turton *et al.*, 2011; Nordfjaern *et al.*, 2010). This paper contributes to the closing of this gap in its aim to explore consumers' lived experience of inpatient care, with a special emphasis on implications for social work practice.

Methodology

This qualitative research project utilises the methodology of hermeneutic phenomenology to explore the experience of inpatient care in a rural mental health facility. Phenomenology is concerned with a person's subjective experience of a particular phenomenon and the meanings and significance attached to it. Intersubjectivity is paramount in this methodology requiring the researcher to explore ways in which he or she is implicated in the construction of meaning (Willig, 2012). Maintaining a reflexive stance throughout the research process is fundamental to phenomenology and crucial in ensuring rigour. In this case, the researcher has maintained a journal and engaged in reflective discussions with her supervisors throughout the project to support the reflexive process.

While the computer software program NVivo10 was utilised to assist with data management and with producing a thematic line-by-line analysis, the primary hermeneutic focus of analysis was achieved through engagement with the data via multiple listening and re-listening to the recorded interviews and reading and re-reading of the interview transcripts. This engagement with the data was modelled on a process of analysis suggested by Finlay (2011) requiring empathic listening, the 'lingering' over powerful and/or puzzling passages and the consideration of lifeworld oriented questions which focus on such things as self-identity, embodiment, relationships and discourse. A phenomenological approach is an excellent 'fit' with recovery principles in that it allows the voices of those experiencing the phenomenon to be foregrounded to generate knowledge and inform practice.

The research took place in a large mental health inpatient facility in rural New South Wales, Australia. The researcher is a social work practitioner employed in the selected research site. The research received approval by the local branch of the National Human Research Ethics Committee. Purposive sampling was used to select respondents for the research and included people who had experienced admissions to the acute inpatient units from one of three perspectives—consumers, workers and managers. Semi-structured individual interviews were held with the respondents which were recorded and subsequently transcribed. Ethics approval allowed the recruitment of consumers admitted to the inpatient unit both on a voluntary basis and as involuntary under the 2007 NSW Mental Health Act and all participants provided written consent. To minimise risk of harm, ethics approval required the co-signature of the treating psychiatrist on the consent form for those consumers who were involuntary at the time of participation.

Of the eight consumers who participated, six were voluntary and two were involuntary inpatients at the time of the interviews. The consumer interviews commenced by asking participants to describe their experiences of inpatient care from their admission, exploring aspects of their experiences as they arose. This paper reports the major findings from the consumer interviews and the implications for social work practice within an inpatient mental health setting.

Respondents in this study who were the recipients of inpatient care are collectively named as 'consumers'. The search for appropriate terminology for care recipients is a contested and murky one (McLaughlin, 2009). The word 'consumer' was seen as the most congruent with a respectful humanistic approach and the one found most predominantly in Australian mental health literature. However, during data collection, the consumers interviewed unanimously applied the term 'patient' to themselves and others who were recipients of the service. This word has therefore been used in some of the discussion within this paper in deference to their preferred term albeit recognising that this may exist as a result of an internalisation of the dominant biomedical discourse within this setting.

As the study was conducted from a qualitative paradigm, the importance of the research lies in the meaning of the findings and implications for theoretical ideas such as principles of the recovery movement and social work. There is no claim that they are generalisable nor that the sample is representative of what people outside this setting might experience.

Findings

The three main themes identified from the consumer interviews are presented here, highlighting the implications for social work practice. Subsequent careful phenomenological re-listening to the interviews reinforced and deepened the understanding of these themes, adding significance to the implications revealed. In reporting the findings, pseudonyms are used to distinguish the different respondents' quotes and experiences.

Overall, consumers' experience of inpatient care was mixed with both negative and positive experiences recounted. The three most mentioned aspects of inpatient care for consumers revealed by the thematic analysis included a plea to be listened to, the value of mutual support and the role of the family.

The importance of listening and communication: 'I just wish they would listen to me'

This quote is representative of the strongly expressed need from consumers to be heard within this environment. Some consumers talked about listening in the context of poor communication from staff about procedural matters such as orientation to the unit and treatment decisions while others felt dismissed and ignored in their efforts to explain and make meaning of their state of being that had initiated an admission. Listening is essential to validation and acknowledgement. Making meaning is a principle of recovery-oriented practice that requires 'space' and time in which the person can reflect, express and articulate those experiences that are causing distress or dislodging a sense of self. In the inpatient setting, consumers can struggle to tell their story in their own words not only because of the assault on their senses from their mental health issues, but also because they come up against an environment dominated by an entrenched biomedical language of symptoms, diagnosis and treatment. Already feeling trapped by racing thoughts, voices or an overwhelming pall of depression compounded by the effects of powerful medication, many of those experiencing inpatient care battle to be heard. The empathic listening of the interviews revealed feelings of resignation, frustration, helplessness and powerlessness:

> I just wish they would listen to me, you know? So like I said it's really frustrating, it's really hard . . . I don't seem to be able to get that through to them you know, they just keep putting it down to arthritis so, and while ever, while ever

> I'm like this I'll never get home because ... (starts crying) I don't feel like I'm getting any better (Delia).
>
> I came here as a person who had memories of the past and that's not a mental illness and they've classified me as schizophrenic. ... Well, it just seems like they're words that, to have control of me while I'm in here (Drew).
>
> ... let them tell their story, let them just feel like they're being listened to, I guess that's probably the most important part (Alan).
>
> Yeah, all they did was just sit down and just wrote everything down and they didn't ask you any questions about anything else, what you were going through ... they didn't take the time, they didn't take enough time with a one-on-one patient to discover what that person is really going through (George).

When the person's version of their state of being is not aligned with the discourse of the medically dominant environment in which they find themselves, feelings of invalidation and dismissal are prevalent. In a paradoxical way, this intensifies their distress and delays any sense of recovery. As Drew puts it, 'They don't want me to dwell about it but they're making me dwell about it ... by not talking about it'. In this case, 'it' is Drew's version of his distressing experiences. Listening in a way that is fully open to a person's recounting of experience is a complex and difficult skill in the field of mental health where training has infused workers with its own language to describe the experiences of those deemed to have a mental illness. This language has been developed to make sense of these experiences for those and by those who have by and large never experienced the phenomenon themselves. Accepting Drew's own description of himself 'as a person who had memories of the past' rather than overriding this description with the acceptable diagnostic nomenclature of 'schizophrenia' offers the opportunity for a dialogue to be opened up in place of the hostility and resistance that is subsequently labelled as 'lack of insight' or 'non-compliance'. In the field of mental health, the art of listening is extended to new levels if it is to fit with recovery-focused practice and truly value lived experience.

The value of mutual support: 'You're not here doing this alone'

Much is written about stigma in the field of mental health and the marginalisation of those who experience a mental illness. The consumer accounts of inpatient care recounted here indicate that, for many, a hospital admission afforded them a rare opportunity to meet others who were encountering similar experiences and emotions. This finding is contrary to the substantially negative view of hospitalisation as recounted in the literature. For some consumers, this was the first time they had ever come across anyone whom they felt truly understood what they were going through. This was a powerfully

validating experience and generated a sense of belonging or collegiate bonding with fellow patients, dispelling the sense of isolation experienced by many outside the hospital environs. When Alan spoke about what he considered to be the primary influence in the improvement of his well-being, he expressed surprise at his realisation of the important role other patients played:

> I think the biggest factor would have to be um, probably the other patients funnily enough, to engage with them, to know their stories, to sort of reflect and go 'hang on this guy's in here for the same reason', it's not just, you're not here doing this alone. I think that helps a lot.

The support of other patients was critical for many at the start of their admission, as they provided orientation in the absence of busy staff, allayed fears and had the time to sit and listen:

> . . . they sort of ran me through it over there cause I was totally oblivious to it all like morning meetings and like who your doctor is and everything, I had no idea about any of that and then you know they were really helpful with me and just running me through that, showing me where everything was (Sam).

> . . . there were people in there with issues like me as well. And it was really good to sit down and talk to someone . . . it made me feel a bit more relaxed, yeah, that I had people to talk to and that's when I started talking to people and started realising I'm not the only one that's been through like a lot of stuff (Carrie).

For Sam, the meeting of other people who understood his lifeworld prompted a reflection about his sense of self in his everyday life. Again, there was surprise in his discovery of what it meant to 'fit in':

> . . . to be quite honest when I, when I was down the street or anywhere else I quite felt like I was the odd person out at times but when I come here I felt like I fitted in. So it felt quite, quite good for me.

Bill shares this experience of alienation in the world outside the hospital setting and the surprise at discovering the connection to others who are sharing this temporary world of inpatient care: 'I was around other people that understood me. Cause you don't get that in the society end of life.'

The feelings of connection and validation that resulted from sharing time with those who have similar experiences is thrown into relief by the apparent limited availability of staff to listen and acknowledge consumer perspectives and possibly reinforced by the onerous nature of the task of trying to explain a condition as nebulous and complex as mental ill health to those who may never have experienced it. This sense of belonging amongst like-minded others is in stark contrast to the world outside the hospital where difference is highlighted and feelings of separation and alienation are the norm. This positive aspect of hospitalisation appears to be an unintended consequence of inpatient care and not one that was deliberately encouraged or facilitated within the setting.

The role of family: 'My family's my strength'

For five of the consumers, it was their family who encouraged them to seek inpatient care. They spoke of the significant role their family played in seeing them through the admission process and keeping up their support throughout the period of care. Contact with their family was crucial in their focus to get well and in keeping them grounded to life. For some, they attributed the love for their family as a major factor in preventing them from taking their own life: 'But the reason I didn't do it was because I care about everyone else around me and how they would feel, like I wouldn't want to do that to them, even though it'd be easier for me' (Sam).

For Carrie, her mental health prior to admission had deteriorated to the extent that she could no longer make decisions and her anxiety was at such a critical level that she feared she would take her own life:

> I thank myself and my uncles for getting me in here at that point because I have seen if I'd let it go and let it go, I'd be six foot under or, or I could be heaps worse and wouldn't be able to bring myself back to a normal person.

Continuing connection with family was identified by Mandy as her incentive to get better: '... having my family in my mind to be better and to go home, that does really help, plays a big role.' Her opportunity to speak with family, who lived some distance from the hospital, throughout her admission was an important motivation for recovery: '... letting you be able to call your family, that helps.'

Mandy also sees the importance of family being informed and supported in turn throughout the period of inpatient care. She states that family need to be reassured that recovery is possible and to maintain hope and optimism that the person they know and love still exists: '... the family need to be reassured that you know, that we can recover ... but we just also need to be understood that we're still, we're still in there.'

Alan also is concerned for his family and appreciates their struggle to understand his situation and is protective of their well-being in trying to deal with it:

> I mean what, what son would like to call up their dad and say 'hey I feel like killing myself'... generally people with that sort of network where parents are there, they just, don't want to put them through that stress.

Understanding of the mental health issues being experienced is also recognised by Carrie as being a difficult task for her husband. She is unsure whether he will accept that her new outlook on life will continue and she expresses concern for the negativity that he may unwittingly convey to her. At the same time, she understands that his acceptance of her changes would be difficult after years of being let down: '... but at that stage it was still early days... and I guess he's probably frightened as well like of me going back and taking off every time we have an argument.'

Family support can be tenuous but it was also recognised as critical for the recovery of these consumers. There are mixed emotions of gratefulness, relief, love, uncertainty, understanding, tentativeness and protectiveness. While opportunities for contact with family members by the consumers themselves was encouraged and supported within the hospital setting, approaches to families by staff was not often commented on and seemed to be inconsistent and sporadic. When asked whether family had been contacted or supported, Alan replied: 'From what I know I don't think so.'

Discussion

In the spirit of recovery-oriented practice, the lived experiences of those on the receiving end of mental health services need to be seriously heard as a legitimate and critical source of knowledge. The three major themes identified by consumers in this study highlight the importance of aspects of personal recovery during an episode of inpatient care. These three themes offer lessons for all mental health workers. In particular, each of these themes constitutes an area of practice that has traditionally been central to social work. Whether listening, peer support and family inclusion are important factors in recovery for consumers in other contexts such as other rural areas, community health services or urban service delivery is a matter for further research.

Listening and communication skills are at the heart of a recovery approach that honours the lived experience of consumers. They are also core to effective social work practice (Trevithick, 2012). These skills can be taken for granted with little consideration as to either their significance or their complexity. In the field of mental health, the components of listening are paramount to acknowledging the person's attempts and at times struggles to describe the phenomenon they are experiencing. To be able to describe an experience as nebulous as mental illness requires its own set of skills and practitioners should be respectful of the consumer's skills in taking on this task. Ife (1999) states that the critical paradigm requires a sharing of skills between client and worker in a process of mutual empowerment and mutual education—a position that mirrors one of the central tenets of the recovery movement. Only then can genuine collaboration occur and from this place of mutual respect an agreed way forward be forged. As noted by Parker (2014), the experiences of consumers will be filtered through the ontology and epistemology underpinning the health professional's approach that in turn arises from their individual discipline training. Truly *listening* to the consumer's perspective in a respectful and validating way is likely to be highly challenging for many mental health workers but should sit comfortably with social workers given that the notion of social justice and listening skills is a defining feature of the discipline.

The notion of peer support was highlighted by consumers in this research. Most of those interviewed highly valued the contact and engagement with

fellow inpatients, appreciating the time to speak with others who had similar experiences. They spoke about 'fitting in', about not feeling like 'the odd man out' and of feeling 'understood'. The experience of marginalisation or alienation is common for people labelled with a mental illness or for whom thinking processes or emotions feel out of control while trying to maintain the routines of their everyday life.

The feeling of connection, support and automatic understanding was a surprise and a relief to these consumers and many attributed the improvement in their well-being primarily to these factors. Consumers did not seek this mutual support out. It was a natural consequence of occupying a common space for a common reason—the reduction of distress and an improvement in emotional and mental well-being.

Loumpa (2012) states that the introduction of peer support is critical to recovery-oriented practice, freeing workers and consumers from professional practices that can be experienced as oppressive. Social work has long understood the benefits of peer support or mutual aid. Pistrang *et al.* (2008) state that the sharing of like experiences can render benefits such as an increased sense of empowerment and self-efficacy and Steinberg (2010) strongly advocates mutual aid group work as a form of strengths-based, anti-oppressive practice asserting that the concept of mutual aid is unique to social work practice. She states that 'no other helping profession places it at its very epicenter (*sic*)' (Steinberg, 2010, p. 55). Putting these factors together—the goodness of fit between mutual aid and anti-oppressive practice, the centrality of mutual aid practice as a social work domain and the value placed on mutual support from these consumer narratives—we find another opportunity for social work leadership within a mental health inpatient setting.

This affirmative social experience afforded by the episode of inpatient care reinforces consumers' personal (or mental) and identity capital as outlined by Tew (2013) and provides a strengths-based approach to identifying resources and strategies to enhance recovery. The presence of peer support and the opportunity to feel like they fitted in are positive aspects of an inpatient admission that could be maximised. Social workers have the skills with which to do this as a form of empowerment practice, creating the opportunity for consciously developing a collective consumer voice as one recovery strategy within this setting.

Family support was integral to five of the consumer participants as a factor in keeping them alive, in supporting their admission and in providing a reason to engage with treatment to work towards discharge. Their narratives about family often provoked tears: this emotional response driven by love, apprehension, gratitude and protectiveness. Acknowledgement of the person's family and social context as part of their recovery capital, according to Tew (2013), is as crucial as any individual therapeutic work to ensure long-term efficacy. Pawar and Cox (2004) also note how informal care systems play a crucial role in recovery. However, family have not always been afforded this level of consideration or appreciation across the history of mental

health service delivery. Glick and Dixon (2002) and Jones (2004) note the predominantly psychoanalytic models of family therapy during the 1960s where families were seen as a causal factor in a family member's mental illness. The experience of family inclusion gleaned from the consumer narratives of this current study appears to be ad hoc and incidental and not 'treatment as usual'. This points to another gap in recovery-oriented practice in an inpatient setting that could be addressed by a strong social work presence and a further opportunity to reposition the 'social' into biopsychosocial.

Conclusion

Aspects of personal recovery such as listening, mutual support and the importance of family are of central importance to recovery according to the consumers interviewed in this study. Recovery is not an easily defined concept in mental health nor is the concept of mental illness or 'madness' itself. This has resulted in a multifaceted response with two, sometimes three, constituents to the notion of recovery. Clinical recovery or the amelioration of symptoms is driven by a biomedical approach while recovery as expressed by consumer lived experience focuses more on a psycho-social approach involving the identification of strengths, promotion of hope and meaning-making.

Mental health services such as inpatient facilities are traditionally geared towards achieving the goals of clinical recovery with minimal focus on the social context of mental illness, thus compromising long-term sustainable recovery. The research reported here gives voice to consumer experience of inpatient care with results highlighting those forms of capital considered central to personal recovery including identity and personal (or mental) capital within a wider social context. Recognising the importance of listening, of peer support and of family is fundamental to social work practice as well as being intrinsic to a recovery approach. Greater emphasis in practice on these aspects will contribute to restoring the balance between the bio and psycho-social aspects of recovery. The alignment of social work values and principles with those of the recovery movement position social workers as key contributors to the transformation of mental health services towards recovery-oriented practice within the challenging setting of acute inpatient care.

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