Children and Youth Services Review 87 (2018) 95–102

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

What does "recovery" from mental illness and addiction mean? Perspectives from child protection social workers and from parents living with mental distress

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ARTICLE INFO

Keywords:
Mental health
Consumers
Child protection
Addiction
Recovery
Social work

ABSTRACT

The mental health consumer movement initiated the development of the recovery approach, in which self-determination, human rights and the living of a hopeful life superseded merely symptom management for people living with mental illnesses and addictions. To what degree has this reimagined path to recovery shaped social work practice? In this paper we analyse the perspectives of eleven social workers doing child protection work in Aotearoa New Zealand. We examine also the accounts of thirteen parents living with mental illness or addiction who have been involved in child custody investigations in Aotearoa New Zealand. We ask whether the social workers understand recovery as possible for such parents, and if so, how they see it occurring. We found that there is a substantial difference between the way the social workers and the parents conceived of such 'recovery'. While parents' descriptions of recovery reflected those of the mental health consumer movement, social workers tended to operate with a focus on clinical intervention, symptom and risk management.

1. Introduction

The concept of recovery, as understood within the mental health consumers' movement, has hope at its heart (Lapsley, Nikora, & Black, 2002; O'Hagan, 2015; Perkins, 2006). Self-determination, a positive approach to 'risk', and a strengths perspective are also core elements (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009; Myers, 2015; O'Hagan, 2015; Roberts & Wolfson, 2006). We will argue that an understanding of this concept of recovery, particularly as it has been inflected in Aotearoa New Zealand (O'Hagan, 2002, 2004), and in recent 'family recovery' literature (Nicholson, 2014; Price-Robertson, Manderson, & Duff, 2017; Price-Robertson, Obradovic, & Morgan, 2017) is necessary for child protection workers engaging with parents who live with mental illnesses or addictions.

How do child protection social workers conceptualise the process of recovery from mental illness or addictions? This question arose in the course of the *Child Custody Research Project* (*CCRP*), a community-university collaboration, including health and social services professionals, people with lived experience of mental illness and academics from the University of Canterbury, New Zealand. The primary focus of the CCRP is to explore how decisions are taken in relation to care and protection, guardianship and family reunification when one or both parent has a mental illness and/or addiction, and to consider how outcomes might be improved. The project's questions emerged from a group of mental health consumers, part of *Awareness*: *Canterbury Action on Mental Health and Addictions*, regarding the experiences of parents with mental illnesses when they become involved in investigations by the child protection services or in custody disputes within the Family Court. As we collected our data, we noticed a significant divide in how the child protection workers and parents, respectively, understood the notion of recovery; this paper involves an exploration of that initial observation. Although the broader context of child welfare work is currently fast changing in Aotearoa New Zealand (Hyslop, 2017; O'Brien, 2016; Webster & McNabb, 2016), there has been, to date, no literature looking at the use of the concept of 'recovery' by child protection workers.

In this article, we consider the perspectives of eleven child protection social workers in relation to recovery from mental illness and addictions. We then consider the experiences of thirteen parents, their own ideas on recovery and whether they felt that these and their strengths as parents were properly appreciated by their children's social

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https://doi.org/10.1016/j.childyouth.2018.02.023
Received 20 October 2017; Received in revised form 12 February 2018; Accepted 12 February 2018
Available online 13 February 2018
0190-7409/ © 2018 Published by Elsevier Ltd.

workers. Finally, we will consider the structural context of social work practice in the child protection sector, arguing that a disciplinary neoliberalism in a resource-poor environment makes it difficult to put a 'recovery perspective' into practice.

1.1. The concept of recovery

Writing from within both the mental health consumers' movement and clinical psychology, Patricia Deegan in 1988 issued a powerful challenge to the then prevalent and pessimistic view that mental illness was chronic, unrelenting and incurable. She described being told, as a teenager, that she was schizophrenic, should give up her dream of being a teacher, and could only hope to 'adjust' to an incurable malady and 'cope' from day to day (Deegan, 1988, p.12). This view that symptom remission alone equates to recovery, and that a full and meaningful life cannot be achieved in the presence of distressing or unusual experiences, continues to exist today. This view has been identified by Le Boutillier et al. (2015) as being called 'clinical recovery', and has strong similarities to the medical model. Far from being recovery-oriented practice, this model puts the focus on symptom management, treatment and medication adherence, attending to the problems, risks, or deficits associated with mental illness, and failing to see any meaning or value in the experience of symptoms or distress. Deegan described the consequences of living with this prognosis as catastrophic for her self-determination and sense of hope:

> It is living in darkness without hope, without a past or a future. It is self-pity. It is hatred of everything that is good and life-giving. It is rage turned inward. It is a wound with no mouth, a wound that is so deep that no cry can emanate from it. Anguish is a death from which there appears to be no resurrection. It is inertia which paralyzes the will to do and to accomplish because there is no hope. It is being truly disabled, not by a disease or injury, but by despair (Deegan, 1988, p. 13).

After months in which she did nothing but smoke cigarettes, watch television and sleep, Deegan found that something both immensely small and deeply profound had changed for her:

> A tiny, fragile spark of hope appeared and promised that there could be something more than all of this darkness...This is the grace. This is the birth of hope called forth by the possibility of being loved. All of the polemic and technology of psychiatry, psychology, social work, and science cannot account for this phenomenon of hope. But those of us who have recovered know that this grace is real (Deegan, 1988, p. 14).

Having gone on to train successfully as a clinical psychologist, Deegan described the process of 'recovery' as a recovery of purpose and meaning in life, of energy for responsible action, of connection with family and friends, and of self-determination. She noted that 'recovery' did not necessarily imply 'cure' (Deegan, 1988, p 14).

The concept of recovery that Deegan was proposing stepped away from the prevalent paradigm of symptom management, whereby a chronic, relapsing illness that created deficits in functioning needed careful and ongoing management by professionals, into a new place entirely (Davidson et al., 2009). It saw 'recovery' as a process of living well, in either the presence or absence of ongoing symptomology. It saw the process of moving forward with a life chosen by people themselves, as the crucial element in building a life rich in connections, purpose and meaning (Anthony, 1993; Bonney & Stickley, 2008). It saw that a mental illness could, in itself, be the wellsprings of growth, success and skill.

Gagne, White, and Anthony (2007) note that there are many similarities, and a broadly shared vision, in the concepts of recovery as used within the fields of mental health and of addiction. However, while mental health recovery is conceptualised as finding meaning, purpose and hope in regardless of the prevalence of mental illness symptoms, recovery from addictions has often been understood to centre around abstinence, though harm-reduction approaches are beginning to broaden this.

More generally, recovery and recovery-orientated practice, remain fraught with different understandings within different contexts of practice. Le Boutillier et al. (2015) noted that clinicians and managers often understand 'recovery' through the notion of 'clinical recovery' – a symptom management model, or through 'service recovery' – sustainability for the organisation. These perspectives are very different from the notion of 'recovery' as developed within the consumer literature.

The New Zealand government was the first in the world to establish a nation-wide policy in 1998 requiring the use of a 'recovery approach' by mental health services (MHC, 2007, p. 7). Within New Zealand, the concept of recovery was further inflected with an understanding of the social determinants of health and wellbeing; partnerships between service users and professionals; and the language of human rights, particularly in a bicultural context. The New Zealand Mental Health Commission published a landmark, bicultural, study narrating the stories of 40 people in their journeys of recovery (Lapsley et al., 2002). The authors note that "at the heart of recovery were fundamental processes of change" (Lapsley et al., 2002: 46) summed up in the mnemonic HEART: Hope, Esteem, Agency, Relations and Transitions in Identity. They showed that emotional growth is possible through the experience of mental illness itself (Lapsley et al., 2002: 100).

2. Methodology

The Child Custody Research Project (CCRP) has completed 53 interviews. These include 13 with parents who have been involved in child protection investigations or family court disputes where mental illness or addiction has been a focus and 11 with child protection social workers. These two groups became a focus of this article because parents have to engage with child protection workers' attitudes during care and protection investigations and proceedings. Interviews have also been completed with legal professionals, healthcare professionals, advocates and support workers; with extended family members; and with foster parents. We use the term 'mental illness', not in relation to specific diagnoses, but to refer to any mental illness or addiction which is severe enough to become an issue in care and protection investigations, or in Family Court, proceedings. The ongoing research project has ethical approval from the University of Canterbury's human ethics committee, and from the Ministry of Social Development's research access committee. All personal names in this article are pseudonyms.

All participants cited as child protection workers were trained social workers, working in child and family care services. The schild protectionworkers comprised two managers for Oranga Tamariki: The Ministry for Children (OT),[1] six senior social workers with OT, one health board care and protection specialist, and two NGO based social workers who carried out intensive support and assessment under contract to OT. The child protection workers were recruited by approaching relevant agencies, with the intention of having broad representation of agencies and personal experiences. Demographic data was not collected for the social workers, but all had more than two years' experience, with the majority having more than eight years' experience. Not all the child protection workers had been exposed to the concept of 'recovery in their training. While all mental health courses in social work education include this concept, not all social workers take a mental health course during their training (Personal communication: David McNabb 2018). Social worker interviews were primarily carried out by a social worker team member through semi-structured interviews which were 40 to 90 min in length. We asked about where

[1] Oranga Tamariki: The Ministry for Children (OT) is the statutory care and protection agency in Aotearoa New Zealand. At the time we did our interviews it was known as Child Youth and Family (CYF) and was part of the Ministry of Social Development.

decision-making worked well and where it did not; strengths and resilience factors; stigma; risks; and where the child protection worker would like to see changes in the system.

The parents were recruited through mental health and social service agencies. The agencies selected clients whose mental health or addiction status had been a factor in Family Court or in child care and protection proceedings, and asked them if they would like to participate. Those who agreed were interviewed, primarily by an NGO based therapist and child protection specialist, n a trauma-informed manner (Decker, Naugle, Carter-Visscher, Bell, & Seifert, 2011). The parent interviews were mildly structured using a conversational approach (Hannerz, 2003); they took anywhere up to three hours. Parents were encouraged to tell their story of living with a mental illness and/or addition, and of their engagement with Family Services, in any way which felt comfortable to them. Extra time was provided before and afterwards for connection and debriefing, and we followed up some days later with a supportive phone call.

The parents comprised four fathers and nine mothers, all of whom self-identified as having a mental illness. In addition, four had been diagnosed with substance use disorders and thus had dual diagnoses. The specific mental illness diagnoses varied; most parents had been diagnosed with more than one disorder, and all the parents said their mental illness and/or addiction had been a factor in child care or custody proceedings. Nine of the parents had children who had been taken into out of home care, while three had only been investigated by the care and protection services. Moreover, three parents had been involved in access or custody proceedings through the Family Court. Eleven of the parents are New Zealand Europeans; one is Māori, and one is an Asian immigrant to New Zealand. The age of the parents ranged from early 20s through to late 40s, with a fairly even spread between those ages.

The interviews were transcribed, anonymised, and coded in NVIVO by a postgraduate student working under the supervision of the first author. Those data coded at both the 'child protection worker' attribute and the 'symptom management and recovery' node were first thematically analysed, and then selected extracts were subjected to a critical discourse analysis. This is a research method developed by Norman Fairclough (2003) which involves close reading for the purposes of identifying conceptual assumptions and ideological underpinnings in written texts. The selected extracts were chosen because they had numerous features characteristic of the social workers' overall discourse available in relatively concise pieces of text. Those data coded at both the 'parent' attribute and the 'symptom management and recovery' node were thematically analysed, with illustrative quotations chosen. Critical discourse analysis was not used with the parent interviews. The first author analysed the social workers' perspectives and the second author analysed the parents' perspectives. The third author checked both sets of analyses for consistency and accuracy.

3. Results

3.1. Child protection worker perspectives on symptom management and recovery

The social workers interviewed, for the most part, appeared not to understand the concept of recovery as used in the mental health consumers movement. When asked about recovery, most responded with a description of symptom management through medication, monitoring, psychosocial support and oversight by professional services consistent with the notion of "clinical recovery" described by Le Boutillier et al. (2015) They tended to see mental illnesses and addictions as chronic or chronically relapsing, thus expecting ongoing challenges, and at times seeing little hope for such parents. However, one social worker, based in a non-governmental organisation [NGO] providing intensive wrap-around support to new parents under contract to OT, was an exception to this general rule. She described the active part clients must play in their safety planning; she also accepted that recovery naturally takes some time. She treated her clients as agents in their own recovery.

With the exception of this NGO-based social worker, several themes emerged in how child protection workers spoke of the issues. First, parents' situations were constructed in a deficit-framed manner, with issues of risk repeatedly highlighted. An example is a story told by a hospital based social worker, describing her involvement with a case manager at the hospital around a mother who was both drinking heavily and self-harming:

> [the client] says she's really open to support, she wants to change, she'll put the child into [Support Foundation A] so he gets support. She's going to not drink around him. A week later she was still drinking around him and [the child] was having to get a towel to mop up the blood. So, I said to [the case manager], I really think it needs to go to CYF. And she said, "Can we just hold off, could I try"? And I said, "You're holding this risk, you know, she's got it". It doesn't matter what [the client] is verbalising, it's got to be different for the child, and it wasn't. So, she let the mother know all the way through that CYF were going to become involved if it didn't change. She talked her through it; CYF came in, they called the wider family together. They safety-planned, so that the child always knew he was absolutely allowed to ring somebody else if mum was drinking or cutting, and Mum absolutely had to accept that. And they did some wider stuff with the school. And Mum kept her relationship with the case manager, just a beautiful piece of work when it goes really, really well.
>
> [Candice: hospital based social worker]

In this story an acute problem was being addressed, according to the teller in an exemplary way in terms of the case manager-client relationship. Yet, the social worker paints the mother in deficit terms and sees her as 'a risk': "You're holding this risk." She repeatedly refers to the mother in relation to problem behaviours and the risk she poses to her son, and never in relation to any strengths she might bring to that relationship. She doesn't see the mother as self-determining. The mother's own sense of herself is seen as irrelevant: "It doesn't matter what she's verbalising…". The mother is subject to coercion: "…and Mum absolutely had to accept that". Grammatically, Candice positions her in sentences at the object level, or in subordinate clauses. The mother is rarely the agent of the action; agency is to be found with the case manager, and with OT, so we have an expert-driven approach. There is no sense of a timeline for recovery. Indeed, the fact that a week after expressing a desire to change she was still cutting and drinking, is seen as evidence that the problem will continue indefinitely. The solution was to be found in a family and school-based safety plan, rather than in any choices the mother might make for her own recovery. Although firm action is needed in an emergency, it wasn't accompanied in this case by the grasping of a 'recovery' opportunity.

In the course of ten of the eleven interviews with care and protection social workers we found no significant elements of the recovery model, as portrayed in the mental health consumer literature. Considerations of risk and safety were paramount. Terms such as 'difficult'; 'concerning'; and the 'impact' of his or her 'mental health behaviour' preponderated. The assumption appeared to be that mental illnesses or addictions are intrinsically and only problematic unless actively managed by professionals, with the full engagement and compliance of the parent client.

A second, and related, theme is that treatment and coping strategies must be expert-driven. In most interviews, social workers suggested that mental illness need not be a problem, as long as the client was engaged with professional services. For instance a social worker responded to a question about client strengths as follows:

> Absolutely, the engagement, following the medication, working with your mental health provider, actually having those plans, the supports, networks of support around you. They are child-focused,

yeah. Particularly if we've got a report of concern about somebody with a mental health problem, if she has a diagnosis or is – yeah, those sort of behaviours that are concerning - then that's what we're wanting.

(Rosie: Oranga Tamariki manager)

Clients were often described in terms of limited agency. Terms such as 'oversight' or 'five sets of eyes on the child' were used. Sentence construction tended to place the parent client in the passive 'object' position, with the active subject of most sentences being a social or health professional or service. For instance, one senior social worker with OT said that the main thing families (i.e. parents) need is support from specialist services, with good family support being a bonus. She went on to say:

I think really in order for parents to develop insight, education, strategies to manage, stay sober or reduce the harm from their addiction, it does take specialist intervention to do that. The parents who say, "I can give up any time on my own, I don't need to go to a drug addiction service", they're the ones we probably really worry about because I don't think that's what the research supports and I don't think it's what my experience from working with other families supports.

(Adriana: Oranga Tamariki social worker)

In this quotation, proactive efforts from the parent to address addiction issues without the support of specialist services are seen as a deficit rather than a potential strength. In spite of her statement that the research doesn't support client-driven recovery, international research has shown that, in general populations, over 70% of people with addiction struggles recover without any specialist intervention and often before the age of 30 (Alexander, 2008, pp. 160–161; Heyman, 2009).

A third theme that emerged in the social workers' discourse was the idea that mental illness or addiction was chronic or chronically relapsing. Repeated references were made to 'the history' of clients, with the implication that this determined the future. "I guess that the assessment is the history" (Mary: Oranga Tamariki social worker). Statements such as 'We're not going to change the borderline personality disorder and we're not going to change the bipolar' (Mary: OT social worker) construct the problem as intractable and undercut any faith in clients' ability to recover and eventually regain care of their children. When asked what 'recovery' from a mental illness might look like, one social worker replied:

I think for mental illness, you're talking more about stability. What's their functioning? What's their ability to do certain things? What stuff is never going to be, is outside their realm of capability? What's required to maintain that level of stability? Are they fully engaged in their mental health where they are actually taking whatever it is that they need, or back to not engaged at all, not even acknowledging that they've got it?

(Bevan: OT social worker)

Low expectations were set in this statement, for 'stability' rather than growth, development or transformation. Certain things were seen to be always beyond reach for a client with a mental illness.

Absent generally from the child protection workers' responses was any idea that the experience of mental illness or addiction might give rise to strengths, and any sense that mental illness or addiction can actually lead to personal growth and development as people grow past the illness (Lapsley et al., 2002; O'Hagan, 2015). Whilst several acknowledged the wish to parent as a motivating factor for the client desiring wellness, and some talked of parenting courses, none mentioned the opportunity to parent as in fact supporting recovery.

However, one NGO-based social worker who does assessments and wrap-around support for new parents under contract to, brought a different understanding of 'recovery' to bear. Three differences from the general approach of the social workers stood out.

First, this recovery-orientated social worker operated with a view that people can grow past a mental illness or addiction, even while she maintained a realistic understanding of the time frames that will operate. "…if this is too much for you right now, then we will advocate that you be given that opportunity to get this sorted out and come back…" (Roberta: NGO-based social worker). Whilst acknowledging the significance of the child's time frames and the need for OT approval, she argued that taking time out of an intensive wrap-around service to look after one's personal mental health is a strength and not a weakness.

She normalised mental distress. When discussing a client who had self-harmed, she said:

I've never been the sort of person that would discharge someone instantly for that behaviour, I'm always about assessing is there a way we can support this person to get to a place where they're doing that less and less, because the reality is it's not going to stop overnight.

(Roberta)

Secondly, she ascribed agency to the client and worked to support them in learning their own self -care strategies.

I mean I worked for a long time with someone who was a serious cutter… just because you have the thought doesn't mean that you'll do it, but when you're having the thought you might want to come and chat to someone about the fact that you've having the thought, because it's about learning to express your emotions.

(Roberta)

Work with this client was ultimately successful.

Finally, Roberta worked with a trauma-informed approach (Briere & Scott, 2014; Van der Kolk, 2014). When describing the multiple traumas some of her clients had experienced, from child abuse, to gang rape, to early involvement with drugs, she noted:

The question would be why isn't she self-harming, not why is she? But why isn't she self-harming, because that's a lot of bloody crap to have had happen to you, and now you're trying to raise a child, and you're being triggered every which way.

(Roberta)

Working with this trauma-informed approach allowed her to see her clients as strong and resourceful people dealing with a difficult set of circumstances, rather than seeing them only as risky and problematic. This approach allowed her to assist her clients in seeing their own triggers, creating their own safety plans and developing their own coping strategies. Although she had the advantage of more resources, and more time with clients, Roberta demonstrated how using a recovery approach might look in child protection work.

3.2. Parents on their experiences of recovery and on the views of child protection workers

The parents interviewed talked about recovery in a way that reflects the notions of the psychiatric survivors' movement; that recovery is a journey, it is non-linear, and that recovery can take place in the presence or absence of the symptoms of mental illness. It involves normalising and finding meaning in experiences, having purpose and a valued role, being an active agent in the process, and engaging in positive risk taking that leads to growth. Though the parents interviewed did not use the term recovery itself, many talked about "managing wellbeing", "keeping myself good", "doing well", being "stable", and being in "complete control" of their mental illness. Key themes that emerged in the parents' recovery perspectives included the ability of parents with mental illness or addiction to recover, the centrality of self-determination for recovery, experiences engaging with risk-focused care and protection services, and the relationship between parenting and recovery.

3.2.1. Parents with mental illness or addiction do recover

Parents interviewed attested to the fact that despite diagnoses of serious mental illness, addiction, and often underlying trauma, recovery is possible. Parents' recovery journeys differed but held important aspects of the consumer movement's definition of recovery in common; personal agency, hope and purpose. One mother, McKayla, talked about reframing the deficits-focussed prognosis she and her family received, using a recovery lens that instead acknowledged her own strength and active role in her journey:

> I've been told that I'll never get better and that's what CYF have been told and that's what my ex-husband was told, that I will never, ever get better from my mental illness. I'll always have it. But always having it doesn't mean it will always define me and control me. I can control it and ninety percent of the time, I'm in complete control.
>
> (McKayla, parent)

In McKayla's redefining of what mental illness means for her, she becomes the active subject in her sentence, after previously being a passive object at the whim of her illness, and, to an extent, the health professional making the diagnosis. For some parents, recovery meant being symptom free, and for others, it meant no longer needing psychiatric medication. “I was over my depression, I hadn't been on pills for about a year and things were looking really good.” (Lilly, parent).

Factors that parents identified as supporting their recovery were greatly varied, and largely were related to their natural supports in family and community, and to self-initiated action. Gaining an understanding of how stress or loss might impact mood, developing healthy coping strategies, understanding triggers, having people to talk to, seeking and finding God, taking medication, coming off medication, travelling overseas, working, studying, contributing to the community, supporting other vulnerable people, parenting, talking to a counsellor or therapist and creative expression through arts and crafts were all mentioned as key aspects of recovery in the parent interviews.

3.2.2. Agency and recovery: the importance of self-determination

While the idea that treatment, insight and coping strategies must be directed by experts featured strongly in the care and protection social workers' interviews, parents talked about how it is imperative that their recovery is driven by them. Furthermore, it is agency, rather than engagement or compliance that is crucial. Symptom management and engagement with mental health professionals and services are not in themselves indicative of recovery for parents with experience of mental illness and/or addictions. Indeed, for many parents, having to engage with services was seen to be an indication of a setback, a lack of personal resources to cope, or a challenge to their recovery, rather than a support of it. Sharon, a mum, described her present mental health as:

> Struggling along. I have lots of periods where I'm really low again and I've been in respite a few times. I had to have another wee stint in [Psychiatric Hospital A], a bit all over the place really. I'm not doing that well.
>
> (Sharon, parent)

These aspects of Sharon's life are presented as an unconnected list, a series of experiences that happen to her, indicative of a difficult time. Accessing respite and a hospital stay are not presented as actions taken in response to feeling low, that enhance or instigate recovery, but as another two markers that she is “not doing that well”.

Where parents talked about having agency, the supports and services they chose to engage with were varied and encompassed a range of options from informal peer support with friends who had similar experiences, phone helplines, and wellbeing plans, through to therapy, medication and initiating a voluntary hospital stay.

> I actually got myself admitted into hospital because it's what I thought I needed to get my medication right… It took me six weeks to come right with help from medication, with help from the mental health admission unit.
>
> (Rob, parent)

Rob's narrative is one of self-determination. Despite accessing a relatively restrictive treatment option, Rob knew from lived experience which supports could be of help and chose to utilise these. As with other references to recovery across the parent interviews, in this quote the parent is the active subject of the sentence. Furthermore for Rob, mental health professionals at the inpatient service and medication, are framed in a secondary, “helping” role, with his will to get better being the central factor in his recovery. Similarly, for a number of parents with previous addiction experience, recovery started with a personal decision - “I just decided one day that I'd had enough of it so I stopped taking it” (Fred, parent). For others, previous experiences with informal and professional support informed the options they sought.

For systems to enable the self-determination central to recovery, a level of trust is needed in people's knowledge of their own recovery journeys, their needs, and how they see the trajectory of their health unfolding. Libby, a mum, talked about her journey to understanding what supports her recovery. In contrast to the care and protection social worker interviews, which emphasise the need for clients to be compliant with direction from their health professional, Libby talks about the value in having a doctor who trusts her judgement and complies with her requests to be linked into particular support when she needs it.

> It took me years to get. You know, to know my triggers and to find ways of coping with my triggers. And finding ways, if I am set off, to cope… It's taken me twelve years to sort of get these mechanisms, and they work for me, they work well. I mean, actually going to my GP and going, hey, put me back on meds, because I'm not feeling the greatest right now, also can you get me some counselling and stuff? And he's like yep.
>
> (Libby, parent)

3.2.3. Engaging with a risk-focused system

Parents spoke about the recovery-blindness of the care and protection services they engaged with, and how a focus on risk overshadowed opportunities to see growth, change and potential. For many, this came in the context of significant weight being given to historical risk over present capability and resilience. Parents described the acknowledgement of their capacity for change as partial or non-existent. They often talked of being expected to give things more time, prove themselves, or show change before being given a chance, though they described struggling to know how to achieve this when any history of risk or unwellness remained in the foreground in their engagement with care and protection services.

> It's still following me. It's like they see these things of who I used to be and they're not talking to who I am now. They're not looking at what I'm doing now. Like I changed my life when I had children, I'm a completely different person.
>
> (Fred, parent)

Conversely, two parents interviewed, who had a relatively late onset of symptoms of mental illness, described the dominant focus of care and protection services being their presentation at the time of the assessment, with little weight given to a long history of stability and good parenting.

> I never had any admissions to psychiatric hospital until the day Doug left me which tells me that was thirty years of life without any major breakdowns which tells me that I'm not that bad, but all they see is the bad and they don't see the thirty years of good, controlled, normal person before that… CYF don't see that. Nobody sees that.
>
> (McKayla, parent)

Like the consumer movement, which understands recovery as a journey, parents talked about incremental, self-initiated steps towards

change. One mum talked about making "a start" by going to get help for her drinking. However she described a static view of recovery by the care and protection service, where her efforts were seen, not as a turning point in her journey, but as complete, yet still insufficient. She reflected on this experience with a sense of lost hope that her own agency lacked value in a care and protection system focused on risk:

> I don't know what else to do really. How else do you prove it? I think it might just be a time thing where the trust is going to be rebuilt again, I guess. I don't really know what else to do.
>
> (Sharon, parent)

A salient example of risk eclipsing other considerations is the experience McKayla recounts of being reduced to her mental illness and its attributed risks. "Nobody was taking any of that into consideration, they were just, this is who she is, these things what she is doing is who she is and she's a risk. I was at risk, yes." (McKayla, parent) In response to being seen as an illness rather than a person, McKayla reframes her situation to being "at risk", which, though a small difference grammatically, has significant implications for the blame or hope that could be extended to her, and the support options that could be put in place.

3.2.4. Parenting and recovery are intertwined

Throughout the interviews, hope, purpose and sense of meaning were closely linked to both recovery, and to people's experiences with parenting. Fulfilling a parenting role was identified often as something that supported recovery, increased stability, encouraged agency in seeking support, and provided a positive identity. Relatedly, loss, or threat of loss, of a parenting role was a destabilising factor for parents in their mental health recovery or sobriety. Parents like Sharon talked about needing to access clinical support to manage the impact of grief on their mental health following loss of custody.

> I'm used to my life as being mother and that's just been stripped away. With my mental health, it's just triggered everything off again. I've had to increase my medications and I need extra support.
>
> (Sharon, parent)

Parents who retained custody of their children also reflected on the overwhelming impact engaging with care and protection services had on their wellbeing. For instance, Claire said:

> The lengths I've gone through to keep my children. Sometimes it's overwhelming what I've had to do to keep my children but when I have my children it's just such a natural thing; I'm just with my children, being a mum and they love me and I love them.
>
> (Claire, parent)

Parent's judged the effectiveness of services in supporting their recovery in terms of the outcomes for their role as parents. Claire, when asked whether being in the inpatient service had been helpful, replied "That was amazing, I got to keep my daughter" (Claire, parent). Her role as mother was pivotal.

The potential for parenting to be a recovery opportunity also featured strongly in the interviews, with children being a primary motivation for parents to address addiction or manage mental health issues. One dad explained this relationship between parenting and recovery saying "I keep myself good because I know that my kids need me" (Jay, parent). Another dad explained:

> I'm only ever thinking about my children. I quit my drug habit for my children. I quit cigarettes because my eldest boy who was two at the time, I was sitting on the doorstep having a cigarette, he sat beside me, picked up this stick and started imitating me. So I went inside and rung Quitline and I haven't smoked since.
>
> (Fred, parent)

The consumer movement holds that recovery is possible in the presence or absence of symptoms of mental illness and parents describe how this kind of recovery, not just symptom management or cure, is compatible with parenting, and with being a good parent.

> The kids know when to sort of, OK mum's having a moment, we'll just leave mum alone. They also know that if I'm in my room and the door's shut, do not enter because I'm having my calm down time because something has happened or been said that has upset me… as far as the kids being affected by it, I don't think they get affected by it as much as what they would if I didn't have my coping mechanisms.
>
> (Libby, parent)

While parenting contributes to motivation for recovery, it is also the case that the knowledge gained in the process of recovery - the ability to model coping skills, have resilience, and be understanding and compassionate are strengths in roles as a parent.

4. Discussion

Overall, we found that most child protection social workers constructed the parents' situation in a deficit-focused manner, highlighting issues of risk. This finding was confirmed by the majority of the parents, who described engaging with child protection services that appeared to them as both risk-focused and recovery-blind. In particular, these parents felt that their present situation was viewed in terms of their history of illness. They described acknowledgement of their capacity for change as either partial or non-existent. This is supported by our finding that many child protection workers see mental illness or addiction as always chronic or chronically relapsing.

There was a disparity between the two groups regarding who has the agency to make change. The predominant view among the child protection social workers was that insight, education and the development of coping strategies are all dependent on compliance with the assistance of professional 'others'. The social workers' attitude that the capacity for change is expert-driven was evident not only in what they said, but how they said it, in the way they constructed their sentences. This was in sharp contrast to what the parents, in line with the consumer movement's definition of recovery, described as their own, self-determined, capacity for change. They described a great variety of paths towards recovery, largely self-initiated, and often related to their natural supports in the community rather than to professional services.

By contrast, one NGO based social worker described how she assisted her clients to see their own triggers and develop their own coping strategies and safety plans. She perceived her clients as strong and resourceful people dealing with a difficult set of circumstances, rather than seeing them only as risky and problematic. It appeared to us that she was putting the recovery model into practice.

Finally, we noted from the parents' account and, to a lesser extent from the social workers' accounts, that parenting contributes to the motivation for recovery. However, only the parents acknowledged that knowledge gained in the process of recovery – and in the very experience of mental illness and addiction – can lead to increased understanding and compassion, and to the development of resilience and coping skills which are strengths in the role of a parent.

Overall, it seems that the child protection workers adhere to a symptom management model whereas the parents clearly sat within notions of recovery as developed within the literature of the mental health consumers' movement. In trying to understand the reasons this may be the case, we turned to the study by Lapsley et al. (2002), "*Kia Mauri Tau*!", which followed the recovery journeys of 40 mental health consumers. They found that people saw the need to recover from the following eight factors:

1. What had always been the matter;
2. The stressful situations that led to the onset of the mental health problems;
3. The symptoms of mental ill-health;
4. Fears and anxieties surrounding the symptoms;

5. Treatments received for the problem;
6. The consequences of the mental health problem and its treatment, involving major life disruptions, leading to isolation, joblessness and poverty;
7. Destruction of self-esteem, trust, optimism, hope and faith in the future;
8. Stigma associated with mental ill-health, shame and discrimination. (Lapsley et al., 2002, p. 45).

Both the language of the social workers and the parents seem to have in common 'fears and anxieties', namely factor four, above. But the focus of fear for each group was quite different. The social workers' fears focused retrospectively around managing the risks posed by behaviours they saw to be arising out of the antecedent factors one, two and three. They saw treatment – factor five – as the principal coping strategy: recovery *through* treatment, as it were.

On the other hand, the parents' fears centred prospectively on factors six, seven and eight, the consequences of mental ill-health, including a sometimes stigmatising engagement with child protection services, and the accompanying sense that their experiences were misunderstood by these services. Treatments, factor five, were seen as helpful in some instances, particularly if they enabled family connections to be sustained, but were not generally central. What was central were the relationships, and particularly the parent-child relationships, that sustained connection, identity and hope.

Rhys Price-Robertson and his colleagues recently noted that recovery emerges within a complex constellation of human, non-human and institutional elements. Families are central to this network, which also includes institutions such as welfare agencies, mental health services and child protection agencies (Price-Robertson, Manderson, & Duff, 2017). There is an intimate connection between a parent's sense of identity, hope, empowerment and self-determination, and the social and structural determinants that sustain him or her in maintaining caring parent-child relationships (Nicholson, 2014; Price-Robertson, Manderson, & Duff, 2017). Recovery, in other words, is deeply relational (O'Hagan, 2004; Price-Robertson, Obradovic, & Morgan, 2017). We found this understanding implicitly present in the parents' accounts of their struggles to maintain their parental roles and identities, and the impact this had on their recovery, while potential or actual loss of children led to destabilisation of their recoveries.

A key idea emerging repeatedly from the recovery literature is the notion that emotional growth is possible, not just past mental illness but through the experience of mental illness itself (Lapsley et al., 2002; O'Hagan, 2015; Leibrich, 1999). Particular to our study, and to other recent studies in the 'family recovery literature' (Nicholson, 2014; Price-Robertson, Manderson, & Duff, 2017), is the potential for the practice of parenting to enhance such emotional growth, recognised by the parents but not the social workers.

Is the current child protection system too focused on risk to support a recovery vision? In order to address this question, we need to return to the Aotearoa New Zealand vision of recovery as grounded in human rights, opposition to stigma, a bicultural framework and the social determinants of mental health (O'Hagan, 2002, 2004).

In his commentary on the current changes to New Zealand's child protection system, Ian Hyslop (2017) argues that the system in Aotearoa New Zealand, like that in England, involves a disciplinary neoliberalism, which focuses exclusively on children, treating parents instrumentally – not as ends in themselves but simply as a means of caring for children - or and understanding them as feckless and risky (Hyslop, 2017, p. 4). Similarly, Tony Stanley warned of "the danger that CYF social workers might construct their role within such a system as increasingly the assessor and manager of high risk" (Stanley, 2007, p.163). Webster and McNabb, exploring the consequences for care and protection practice of the new public management philosophy influencing the organisational environment, have called for a return to centrality for relationship-based practice (Webster & McNabb, 2016, p. 51). Hyslop quotes the crucial question asked by Featherstone, White and Morris: "Is it ethically desirable to focus on rescuing children and leaving their parents behind in a society riven by inequalities?" (Featherstone, White, & Morris, 2014, p. 3).

Mental illness doesn't arise in a vacuum; the social determinants of mental illness are well known (Compton & Shim, 2015). Yet, the statutory child protection system in New Zealand is resource-hungry, time-poor, and riven by a child-centrism that treats children as if they can be isolated from their broader family, whanau or community context (Featherstone et al., 2014; Hyslop, 2017). Given the realities of this system, relationship-based practice which is an essential recovery competency (O'Hagan, 2002, 2004; Price-Robertson, Obradovic, & Morgan, 2017) may be structurally excluded from statutory social work practice (Munro, 2011).

It is thus not surprising that the one social worker we found who was practising in a consistently recovery-orientated manner was working for an NGO, and was thus outside the statutory child protection system. To put 'recovery' at the heart of child protection practice, a generously resourced system, which focuses on relationship-building and allows social workers to spend time and to exercise discretion in the interests of working with whole families, will be required. Alongside this, a genuine commitment to practising in a recovery-focused way, by individual practitioners, can make an enormous positive difference.

We recommend that all child protection social workers are trained in the recovery model, as inflected within the Aotearoa New Zealand mental health literature (O'Hagan, 2002, 2004). Moreover, child protection workers need to be given the time and resources necessary to build relationships with parents and children, and to get to know their strengths. Finally, structural change to child protection practice might be necessary to recognise the non-linear timeframes by which recovery from mental illness and addiction occurs for parents and other family members. Family reunification, and thus hope, must be held out as a possibility and parents with mental illnesses and addictions must not be abandoned without support.

5. Limitations

a. The parent participants in this study are not representative of Oranga Tamariki's clients as a whole. While approximately 60% of Oranga Tamariki's clients are Māori, 85% of our parent participants are New Zealand Europeans. This reflects the demographics of the research team; many Māori mental health and social service agencies prefer to engage on such a sensitive topic with Māori researchers. See the work of Paora Moyle for a Māori perspective on care and protection (Moyle, 2013). Nevertheless, the fact that the experiences of parents with mental illnesses in the child protection system have not been a focus of research in New Zealand before makes this research important.
b. This research is based in a single city within Aotearoa New Zealand, and thus its generalisability to other regions and centres is limited. Child protection services across different regions of Aotearoa New Zealand are not uniform.
c. The focus of the CCRP was on decision-making and not understandings of recovery. Thus recovery models were not a systematic focus of enquiry during the data collection phase of the project.

Funding

This work was supported by the Oakley Mental Health Research Foundation; the New Zealand Schizophrenia Research Group, Annual Shchizophrenia Research Awards; and the University of Canterbury, School of Language, Social and Political Sciences.

Conflicts of interest

None.

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