Developing a Recovery Oriented Service Provider Resource for Community Mental Health Organisations

LITERATURE REVIEW ON RECOVERY

August 2009

Prepared by the NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG)

Contents

1.   Executive Summary

The NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) and the Mental Health Coordinating Council (MHCC) are undertaking a joint initiative to develop a resource that provides practical support to mental health community sector organisations[1] in incorporating the philosophy of "recovery" into service delivery practice. The findings from this review will then inform the focus for undertaking consumer and service provider consultations to provide further direction for developing a practical guide for implementing recovery oriented service provision in mental health community sector organisations. The literature review will also assist in highlighting where practice and philosophy conflict and guidance on how service providers can work within this.

The purpose of this literature review is to examine the concept of recovery. This literature review is the initial step in this process, and examines the barriers to recovery and the facilitators of recovery, and to suggest what needs to happen to make genuine recovery oriented service delivery a reality.

This literature review details:

The history of recovery
- There is evidence that people living with mental illness can recover. Recovery orientation is now acknowledged in policy as being an aim of service delivery, both in Australia and internationally.
- The recovery movement can be traced to the United States in the 1970s and 1980s. This has heavily influenced the notion of recovery in policy and practice in other countries. Australia has embedded the notion of recovery into policy, but there is criticism that this has not yet translated into practice.

Defining recovery
- The literature identifies a strong need for services to have a concrete definition of recovery to draw on in practice. However definitions of recovery are not concrete in nature and are shaped by individualised definitions in order to make recovery meaningful and useful to the individual. This suggests that there may be a need to provide concrete concepts surrounding recovery to guide services in practice, whilst leaving room for consumers to define their own concepts of recovery to aid their own personalised journey.
- It is identified in this review that much of the literature draws on individual story telling to capture the complexity of defining recovery.
- This review has found that the Anthony (1993) definition of recovery is pervasive in both literature and policy. However, it is essential that consumers have input into a recovery definition. As a basis for consultation, this review identifies that key themes in

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[1] For the purpose of this review, the term "mental health community sector organisations" will be used to refer to mental health non-government organisations in NSW.

defining recovery include that recovery means being able to live a meaningful life, both personally and in the community; redefining a positive sense of identity; making certain life adjustments; overcoming symptoms, stigma and discrimination; and living with hopefulness for the future. It needs to be acknowledged that recovery means different things for different people, and that it can be viewed as both a process and an outcome.

Ways to view recovery

- There are two models of recovery, which are suggested to be in tension with each other.

    1. The medical model drives the clinical view of recovery; recovery is objective and understood to be a return to a former state of health. Outcomes include reduced symptomatology, hospitalisation and medication use.

    2. The personal view of recovery is driven by people's lived, subjective experiences of mental illness and recovery, and challenges the notion of permanent mental illness. Outcomes include empowerment, hope, choice, self-defined goals, healing, wellbeing and control of symptoms.

Concepts and facilitators of recovery

- Concepts and facilitators of recovery include taking control of one's life through individual responsibility. This includes acceptance of illness, hope for the future, identity and empowerment, and advocacy. Other key concepts important to recovery include understanding one's illness, medication and symptoms; developing a healthy lifestyle; having supportive relationships; nurturing one's whole self and spirituality; and social inclusion in the community, including access to education and training, employment, and accommodation.

Recovery models used in practice

- Identified models that some services use to deliver recovery-oriented services include the Strengths Model, the Tidal Model and the Wellness Recovery Action Plan (WRAP).

Recovery-based tools for staff and mental health workers

- Identified tools for staff and mental health workers to use to enhance recovery oriented service provision include the Collaborative Recovery Model, Australian Mental Health Work Qualifications and Training, and Recovery Self-Assessment.

Barriers to recovery

For individuals

- Identified barriers to a person's recovery at an individual level include self-stigmatisation, the side effects of medication and the "frenzied saviour response" (Deegan, 1996) of a person's family, friend or carer.

For consumers as a collective group

- Identified barriers to recovery for consumers as a collective group include when a person becomes hopeless and passive in their care. Stigma and discrimination also hinder recovery.

At the staff/mental health worker level
- Identified barriers to a person's recovery at the worker level include a person not being provided with adequate information about service options and non-drug alternatives; the worker assuming an expert role; a lack of respect for consumer choice and rights, recovery goals of a person conflicting with those of their clinician; staff attitudes, including lack of hopefulness and stigma and discrimination in services; the imperative of workers to use medication; the lack of access to health care professionals; and staff training that focuses on deficits rather than strengths. A contentious barrier to recovery is balancing risk and recovery and it is suggested that workers may discourage people from taking necessary risks on their recovery journey.

At the systems level
- Identified barriers to a person's recovery at a systemic level include the tension between the medical model (clinical view of recovery) and the subjective nature of recovery (personal view of recovery). Barriers reinforced by the medical model include power imbalances between health care professionals and consumers, the deficit-based language inherent in the medical model, assumed chronicity of illness, and compliance.
- Balancing the duty of care and risk management is a challenge identified in providing recovery oriented services. Health care professionals have indicated that risk mitigation necessarily reduces client choice on occasions where people are severely disabled by their mental illness and present a risk to themselves or others.
- Further challenges include that the recovery approach may have the impact of devaluing professional help, and that in Australia there still exists a large gap between recovery in policy and practice.

Principles for recovery-oriented service delivery
Principles for recovery-oriented service delivery include services that:

- Are person-centred
- Promote self-determination and individual responsibility
- Treat people as equals
- Are culturally respectful
- Emphasise strengths and wellness
- Foster hope and empowerment, and use empowering language
- Retain staff who work within a recovery framework and have a positive attitude that reflects that recovery is possible
- Support community integration and social inclusion
- Provide a variety of treatment options
- Recognise that lived experience is essential in informing service delivery
- Challenge stigma and discrimination
- Facilitate consumer participation
- Protect human rights
- Encourage family and peer support, and acknowledges the benefits of such support
- Strike a healthy balance between personal risk and growth
- Staff believe that recovery is possible

Making recovery orientation a reality – what needs to happen?

Individuals
- To make recovery a reality, individuals need to be accountable for their own behaviour, set goals, go at their own pace and share their recovery stories with others.

Services and staff
- To make recovery a reality, services need to experience a cultural shift to embrace consumer self-directed care. Many services have adopted a person-centred care model, which involves services empowering consumers to take control and be the primary decision-maker in their own treatment, care and goals for recovery. While this is a considerable progression from medical models of care, self-directed care is the goal of recovery oriented services. This is where a consumer is supported to direct their own care, and to manage their own recovery. The role of services and staff in this type of model is different to that in person-centred care, requiring the mental health worker to be guided by the consumer. Services also need to conceptualise mental illness in a way that can foster hope and empowerment for a person's recovery, and value people living with mental illness. This needs to be a component of workforce training and development.
- Staff attitudes must align with recovery orientation principles, and the belief that recovery is possible.
- Consumers need to be able to participate at all levels of service delivery and staff must recognise the value of consumer input in the improvement of services.
- It is important that options for choice are made available, where possible, in situations where people are unable to make decisions due to illness or incapacity through mechanisms such as crisis prevention planning and Advance Directives.
- Services need to be able to work collaboratively with consumers to support a person's risk taking and personal growth, where this risk taking does not increase a person's risk to themselves or the community.
- Services need to appreciate the validity of people's personal experiences of mental illness in informing service delivery.
- Future directions for service delivery should include appropriate benchmarking around recovery indicators, strengthening the evidence base for recovery and future research into recovery.

Systems
- To make recovery a reality at a systems level there needs to be a greater awareness of mental illness, and a determined effort to eliminate stigma and discrimination.
- Consumers need to be able to participate at every level of the mental health system.
- A greater awareness of human rights in the community needs to support this.
- The language that is used to describe mental illness needs to shift from being deficits-based, and be reframed to engender hope and empowerment.

Recommendations
Nine project recommendations are made on the basis of undertaking the Literature Review

and consultation during the early stages of project planning which are intended to provide direction for further consultation with consumers and service providers towards the development of a resource to support the NSW community mental health sector in delivering recovery oriented services.

1. Include a broad definition of recovery in the resource in order to operationalise recovery concepts in practice.
2. Further consult with stakeholders, including consumers, service providers and carers to create a definition of recovery oriented service provision to guide the resource.
3. Acknowledge in the resource that recovery means different things to different people: consumers, their families, carers, service providers and the wider community. As such the resource could be written to support these different roles and functions.
4. Identify in the resource ways that recovery can be facilitated. This could be presented through case studies and/ or examples of what has helped people along their recovery journey.
5. Identify in the resource barriers presented at the individual level, the clinical level and the broader community level, and present strategies and/or resources for overcoming these barriers.
6. Outline in the resource key principles of recovery oriented service delivery, based on the principles outlined herein and further consultation.
7. Identify in the resource successful models of recovery oriented service delivery that have been used in practice.
8. It may be useful in the recovery resource to:
   • Further investigate the role of service leadership and management, and what is required to support their transition to recovery oriented service provision in practice.
   • Identify potential tools to support a shift in service culture towards recovery oriented service delivery.
   • Further investigate the impacts of staff attitudes and language use, and how these can best support recovery orientation in practice.

9. Consider in developing the resource that different cultural conceptualisations of mental illness exist.

There are a number of issues raised by this review that are beyond the scope of this project, but are important to recognise as identified areas for further work to make recovery orientation a reality. These include:

• That stigma and discrimination towards people living with mental illness is pervasive, and overcoming this requires a cultural shift towards accepting recovery orientation in services. The greater acceptance of mental illness in the wider community would also help reduce stigma and discrimination.
• Creating benchmarks around recovery indicators across mental health community sector organisations.
• Strengthening the evidence base and research around recovery.

A note on language:
Through out this literature review, the term "mental illness" is a broad term used to describe people who experience mental health problems, mental disorders and mental illness.

1.   Introduction

The NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) and the Mental Health Coordinating Council (MHCC) are undertaking a joint initiative to develop a resource that provides practical support to community mental health sector organisations[2] in incorporating the philosophy of "recovery" into practice.

NSW CAG is the peak, independent, statewide organisation representing the views of mental health consumers at a policy level, working to support and achieve systemic change. NSW CAG's vision is for all mental health consumers to experience fair access to quality services that reflect their needs. NSW CAG has identified through consultations with consumers that more work is needed to move mental health services towards delivering recovery oriented services.

The MHCC is the peak body for non-government organisations working for mental health in NSW. MHCC provides leadership and representation to its membership, and seeks to improve, promote and develop quality mental health services to the community. MHCC facilitates effective linkages between government, non-government and private sectors, and participates extensively in public policy development.

The Project has commenced in response to the perceived lack of understanding about what "recovery oriented service provision" means in practice, for both consumers of services and for workers delivering these services. This is combined with the growth of the community mental health sector in NSW, the need to strengthen the quality of service delivery for people living with mental illness, and the need for service providers to have a resource that provides practical information on how to delivery recovery oriented services.

In response to this gap, the purpose of this Project is to create a resource that will guide service staff in community mental health sector organisations in providing recovery oriented service provision in practice. The Project will explore what is meant by "recovery oriented service provision", and will seek to derive principles around recovery oriented service provision and examples of recovery oriented practice. This will be achieved through face to face consultations with service staff and consumers in a rural location, Wagga and a metropolitan location, Parramatta, as well as through broader internet-based consultation across the state with consumers, service providers and carers. The final outcome will be a resource for mental health workers in community mental health sector organisations across NSW. The form of this resource will be determined as an outcome of the consultation process. This Project has been funded through the Infrastructure Grants Program, NSW Health, and is administered by MHCC.

This literature review is the second step in this Project, and will be used to provide stakeholders with a broad overview of what is meant by recovery, how the concept of recovery has informed service delivery, and identification of what is needed to make recovery oriented service provision a reality. The review is intended to provide a general overview of

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recovery and recovery oriented service provision to provide direction for the project and consultations, and to generate discussion. It is not meant as an exhaustive review of all the literature nor all tools or models of recovery oriented service provision.

The stages of this Project include:

Step 1: Governance structures of the Project established, including a Steering Committee and Reference Group (July 2009)

Step 2: Literature review to explore the concept of recovery: including barriers to recovery and facilitators of recovery, and to suggest what needs to happen to make genuine recovery oriented service provision a reality (Finalised August 2009)

Step 3: Consultation with consumers, service providers and other key stakeholders (September and October 2009)

Step 4: Development of resource to guide recovery oriented service provision in mental health community sector organisations in NSW (Expected completion February 2010)

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2.   Methodology

The literature search was conducted during April and May, 2009. Literature was identified from the following sources:

- Journal databases searches, including searches of Informaworld Journals, Synergy Blackwell, ProQuest Research Library and ProQuest Health and Medical Complete, using the keywords and phrases "recovery", "mental illness", "mental health", "recovery orientation", "mental health services", "consumer movement", "defining recovery", "Australia", "United States", "America", "United Kingdom". These were either used singularly or in combination with each other.
- Google and Google Scholar was also searched with these keywords and phrases.
- Key references within the articles obtained from the above sources were accessed. Key references are those that featured predominantly in the literature.
- Australia's current and previous mental health policies.
- Other country's mental health policies, including New Zealand, America and the United Kingdom.

The literature review was then distributed to the Reference Group in July 2009, and feedback from the Group informed amendments included in this final literature review.

Limitations in the sourcing of literature needs to be acknowledged. The two month time frame to write the review impacted on the extent of literature that could be incorporated into this review. Certain countries were included in the search terms, as preliminary readings indicated that the United States, New Zealand, Australia and the United Kingdom all have a recovery orientation focus in policy, and provide examples of best practice and empirical studies conducted into recovery and mental illness.

3.   Historical Background

General background

The idea that people can recover from mental illness has only come about in recent decades. Before this time, the prevalent belief was that recovery for people living with mental illness was not possible. This resulted in people being institutionalised and closed-off from ordinary life in the community (Allott, Loganathan, & Fulford, 2003; Barnett & Lapsley, 2006). Negative perceptions and an expected poor prognosis of severe and mental illness underpinned the dominant beliefs about mental illness, and have impacted on the enduring stigma and discrimination towards people living with mental illness (Allott et al., 2003).

Now there is evidence that people with mental illness can recover (Andreson, Oades, & Caputi, 2003, p.587; Carpenter, 2002; Davidson, O'Connell, Tondora, Styron, & Kangos, 2006, p.642; Kelly & Gamble, 2006, p.247; Mead & Copeland, 2000, p.317) and that this can occur through the provision of treatment and care in community-based settings. Fisher (2001, BO3) outlines:

> I have recovered from schizophrenia. If that statement surprises you – if you think schizophrenia is a lifelong brain disease that cannot be escaped – you have been misled by a cultural misapprehension that needlessly imprisons millions under the label of mental illness.

A recovery orientation to service provision is forging a clear direction about how mental health services, community mental health sector organisations and related sectors should provide care and treatment for people living with mental illness. This is evident in policy at an international and national level, with many countries seeking to develop services that work within a recovery orientation (See Commonwealth of Australia, 2003, 2009; Health Scotland, 2008; Mental Health Commission of Canada, 2009; Mental Health Commission of New Zealand, 2008; NSW Health, 2008).

> **There is evidence that people living with mental illness can recover. Recovery orientation is now acknowledged in policy as being an aim of service delivery, both in Australia and internationally.**

Recovery in the United States of America

The documented history of recovery for people living with mental illness is strongly influenced by the American perspective and literature on recovery (O'Hagan, 2004). It is suggested that the recovery movement had its genesis in the United States (Meehan, King, Beavis, & Robinson, 2008), and began to take form in the 1970s and1980s when people with the experience of mental illness began speaking and writing about their experience of recovery (Ahern & Fisher, 2001, p.24; Carpenter, 2002). This can be traced to the psychiatric survivor movement (Deegan, 2003, p.373; Ellis & King, 2003). People who did not have the lived experience of mental illness were excluded from consumer organisations, as consumers

found their radical views on mental illness were not shared by practitioners or the general public. These organisations were influenced by black, gay, and women's liberation movements of the time (Schiff, 2004, p.213).

Frameworks of recovery in America in the clinical setting were developed primarily by professionals and academics rather than people living with mental illness (Casey, 2008). This vision of recovery was exported from America to other countries such as Australia and New Zealand, and consequently reinforced the dominance of psychiatric rehabilitation and the biomedical model (O'Hagan, 2004). It is noted that America and New Zealand were the first countries to embed recovery principles in their health policies (Ramon et al., 2007).

Recovery in Canada

Canadian mental health policy and practice has developed with influence stemming from American practice. During the 1970s and 1980s the Canadian Mental Health Association, supported by the Canadian Government and the United States National Mental Health Association met to discuss recovery practices in mental health care (Rochefort & Goering, 1998, p.114). Discussions highlighted the need for greater support services for consumers and a community resource base for developing networks of care (Goodrick, 1998, p.65).

In the 1980s programs such as the Mental Patient's Association in Vancouver began operating drop-in centres and provided residences for mental health consumers to meet the need for increased support. Housing was provided for psychiatric patients throughout Canada as an opportunity to "escape hospitalisation and become responsible for their own care", demonstrating a trend towards self-help programs in line with American practices (Goodrick, 1998, p.87).

Stronger focus has currently been placed on putting the consumer in the role of the case manager, with initiatives in Canada offering more options for recovery, with larger support networks, and consumer created recovery programs (Chamberlin, 1990, p 47). Further, there has been sustained funding allocated to the Mental Health and Addictions Program to provide consumers with recovery oriented mental health services (Berger, 2006, p.466-467).

Recovery in New Zealand

Gawith and Abrams (2006) provide an account of the recovery movement in New Zealand. They document that in the 1980s some New Zealand psychiatric survivors were in contact with American, United Kingdom and European organisations that were starting to question the values and philosophy behind psychiatry. The first consumer networks for people living with mental illness appeared in the early 1990s in New Zealand (p.143).

In New Zealand, policy makers were critical of the American conceptualisation of recovery, as it was seen to be driven by professionals rather than service users (O'Hagan, 2001; O'Hagan, 2004). Furthermore, American recovery literature was criticised for its lack of acknowledgment of important issues such as discrimination, human rights, cultural diversity or the potential for communities to support recovery (O'Hagan, 2001; O'Hagan, 2004; Roberts & Wolfson, 2004).

New Zealand is currently regarded as having one of the most coherent and progressive national recovery policies internationally, with advanced concepts of recovery and recovery

orientated services and practices (Allott et al., 2003; Gawith & Abrams, 2006; Schinkel & Dorrer, 2007, p.16).

Recovery in the United Kingdom

The recovery movement in the United Kingdom developed in the 1970s and 1980s. This movement was driven by the shift towards community-based care and the stories of ex-service user mental health professionals and activists, having roots in the civil rights movements of the 1960s (Allott et al., 2002). Groups of professionals and consumers formed in response to conditions in psychiatric wards, the closure of long-stay psychiatric services and the need for consumers to have a greater role in choices affecting their quality of life (Wallcraft & Bryant, 2003, p.3).

Recovery was first acknowledged in a UK policy document in 2001. Current policy directions include the vision for the transformation of mental health services to allow consumers to be active partners in their treatment, achieve their potential, and be more socially competent and less socially isolated (Ramon et al, 2007; Schinkel & Dorrer, 2007, p.18).

Recovery in Australia

The understanding of recovery in Australia is most heavily influenced by recovery literature from the USA, but also from Canada and New Zealand (Rickwood, 2004; Slade, Amering, & Oades, 2008, p.131). It is suggested that the term "recovery" has belatedly been adopted in Australia from the late 1980s (Lakeman, 2004, p.212; McGrath et al., 2007). It has become popular in mental health discourse and influences policy directives and service delivery initiatives (Meehan et al., 2007; Rickwood, 2004; Slade et al., 2008).

All Australian states and territories have initiatives underway related to recovery, although there is considerable variation evident in the level of knowledge, commitment and implementation (Rickwood, 2004).

In Australia, consumer groups have been the main drivers of the recovery movement (Ramon et al., 2007). In addition, the non-government sector in Australia has been promoting and applying the use of recovery from mental illness in its literature and many program guidelines since the early 1990s (Ramon et al., 2007, p.115).

Australian Policy and Recovery

National Policy
Australian mental health policy has seen the notion of recovery gain prominence since the National Mental Health Strategy was endorsed in 1992. This Strategy contains plans that are updated every five years. While the Second National Mental Health Plan referred implicitly to recovery from mental illness, it was the Third National Mental Health Plan that placed recovery from mental illness at the core of service provision (Ramon et al., 2007, p.115). The Council Of Australian Government's (COAG) National Action Plan on Mental Health 2006-2011 also aims to facilitate recovery through the strengthening of mental health services.

The National Mental Health Strategy was originally endorsed by Government Ministers in 1992, and includes:

- The National Mental Health Policy (Commonwealth of Australia, 2009)
- The National Mental Health Plan (Commonwealth of Australia, 2003)
    - The first Australian National Mental Health Plan (Commonwealth of Australia, 1992) provided directives for the restructuring of mental health services in to mainstream services.
    - The second National Mental Health Plan (Commonwealth of Australia, 1998) emphasised early intervention and early prevention, and mentions "recovery" for the first time (Ramon et al., 2007).
    - The third National Mental Health Plan (2003) is explicitly recovery focused, directing "a recovery orientation should drive service delivery" (p.11).
    - The fourth National Mental Health Plan is currently under development.
- Mental Health Statement of Rights and Responsibilities (Commonwealth of Australia, 2000)
- Australian Health Care Agreements

State Policy

Mental health policy in New South Wales has evolved to incorporate an increasing focus on recovery orientation. Policies that support recovery orientation in service delivery include:

- NSW Community Mental Health Strategy 2007-2012 (2008)
- NSW: A New Direction for Mental Health (2006)
- Interagency Action Plan for Better Mental Health (2005)

General Policy

The Australian Government commissioned the paper *4As Framework for Preventing Further Episodes of Mental Illness* (Rickwood, 2006, p.iv). This framework was created as a basis to inform recovery oriented policy, programs and practice relating to mental health service provision and people living with mental illness. The 4As are:

- *Awareness* – awareness of mental health status and understanding of the factors that affect mental illness, including potential vulnerability to further episodes of illness.
- *Anticipation* – planning for future mental health in terms of self-management, recovery, continuing of care and crisis planning.
- *Alternatives* – availability of self-management and service alternatives that address all the risk and protective factors for mental health according to a holistic approach.
- *Access* – early, easy and equitable access to services that meet all the changing care needs of people who have been seriously affected by mental illness and their families and carers.

While in Australia the impetus for recovery orientation to drive service delivery in policy is evident, there is an acknowledged gap between the rhetoric of policy and the reality of its application into service delivery practice (Happell, 2008a, 2008b; Ellis & King, 2003, p.3; O'Connell et al., 2005, p.378; Rickwood, 2004, p.2).

- ***The recovery movement can be traced to the United States in the 1970s and 1980s. This has heavily influenced the notion of recovery in policy and practice in other countries.***

- ***Australia has embedded the notion of recovery into policy, but there is criticism that this has not yet translated into practice.***

- ***New Zealand is currently regarded as having one of the most coherent and progressive national recovery policies internationally, with advanced concepts of recovery and recovery orientated services and practices.***

4. Defining recovery

A common theme revealed in the literature is that there are numerous definitions of what recovery means. It is identified that recovery is an individual process that is shaped by each person's unique experience of mental illness, and the meaning that each individual attaches to this concept (Meehan, 2008, p.178; Ministry of Health, New Zealand, 2008; Mueser, 2002, p.1273). Recovery can be seen as journey; an ongoing, non-linear process that encompasses a number of experiences and stages (Kelly & Gamble, 2005, p.246; Mancini, Hardiman, & Lawson, 2005, p.49) where a person is capable of recovering even if their mental illness is not cured (SWAHS Mental Health Network, 2008, p.146).

This view of recovery in the context of mental health is in contrast to the everyday use of "recovery", which implies full recovery to a state of wellness (Rickwood, 2004, p.1). Simply, recovery includes living well in the presence or absence of mental illness.

Definitions of recovery emphasise different factors that can enhance the recovery journey, including:

- The ability to lead a meaningful life; to have meaningful roles, relationships, and to be able to actively participate in the community (Anthony, 2003; Farkas et al., 2005, Fisher, 2008; p.141; McGrath, Bouwman & Kalyanasundaram, 2007, p. 2; O'Connell et al., 2005, p.378; Ridgway, 2001; Townsend & Glasser, 2003).
- Redefining a positive sense of identity founded on hopefulness, growth, empowerment, self-determination, and rediscovering strengths and abilities (Andreson et al., 2003, p.589; Mueser et al., 2002, p.1272; Rickwood, 2004, p. 2) where the "former illness-dominated identity is discarded" (Mancini, Hardiman, & Lawson, 2005, p.48).
- Transcending symptoms, psychiatric disabilities and social handicaps (Provencher, Shery, & Mueser, 2002, p.133) and addressing issues such as discrimination, inclusion, power, poverty, internalised stigma, abuse and trauma (Davidson et al., 2006, p. 646; Deegan, 1996, p.12).
- Changing one's attitudes, values, feelings, goals, skills and/or roles (Anthony, 1993).
- That recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them (Mental Health Commission New Zealand, 1998, p.1).
- An individual's capacity to lead a fulfilling life that is not dominated by illness and treatment (Queensland Health, 2008, p.2).

A pervasive theme in mental health recovery literature is that a concise definition of recovery is hard to determine. It is acknowledged that recovery means different things to different people (Kelly & Gamble, 2005, p.246; Buchanan-Barker & Barker, 2008, p.94), and that not every view of recovery will fit with every person's belief system and perception of reality (Campbell, 2003, p.587). The term can be confusing, at times contradictory (Davidson et al., 2006, p.640; Slade, Amering, & Oades, 2008, p.128), and is not well understood by either the consumers who are "expected" to recover or by the professionals and policy makers who are expected to help them (Jacobson & Greenley, 2001, p.482).

This is partly due to recovery being described as both a process and an outcome; being "a journey as much as a destination" (Mental Health Commission, New Zealand, 2007, p.21), presenting the difficulty that "this inherent subjectivity means that the objective measurement of recovery in individuals is problematic" (Slade et al., 2008, p.135). Some accounts of recovery indicate that people experience a defining moment or turning point before which the individual felt stuck, perhaps denying the illness because of anxiety or unresolved grief for loss of health and future (Roberts & Wolfson, 2004, p.40; Schiff, 2004, p.216).

One of the most frequently espoused definitions of recovery is from Anthony (1993, p.13):

> *Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and 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 as one grows beyond the catastrophic effects of mental illness.*

Anthony's conceptualisation of recovery elaborates that people can recover from mental illness even when the illness is not cured, and that the process of recovery can proceed in the presence of continuing symptoms and disability (Roberts & Wolfson, 2004). Anthony is credited with challenging mental health services to make recovery vision their practice in the 1990s (Carpenter, 2002).

This definition is pervasive in Australian policy as illustrated by its use in:

- The *National Mental Health Policy 2008* (Commonwealth of Australia, 2009, p.31).
- The South Australian *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012* (South Australian Social Inclusion Board, 2008).
- The *ACT Mental Health Strategy and Action Plan 2003-2008* (ACT Health, 2004, p.92).
- Western Australia's *A Recovery Vision for Rehabilitation: Psychiatric Rehabilitation Policy and Strategic Framework* (2004, p.48).
- The NSW Health *Framework for Rehabilitation for Mental Health* (2002)

A further definition used in Australia is that of the US Substance Abuse and Mental Health Service Administration (SAMHSA, 2004,p.1).

> *Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.*

This definition was constructed consensually after a consultation process with 110 expert panellists, including mental health consumers, family members, service providers, advocates, researchers, academics, public officials and others.

In Australia there is currently no consensually agreed definition of recovery.

Anna Schiff, a consumer and professional, described that:

> *To me, being recovered means feeling at peace, being happy, feeling comfortable in the world and with others, and feeling hope for the future. It involves drawing on all of my negative experiences to make me a better person. It means not being afraid of who I am and what I feel. It is about being able to take positive risks in life. It means not being afraid to live in the present. It is about knowing and being able to be who I am (2004, p.215).*

Shepherd, Boardman and Slade (2008) identify that there are dangers of a "reductionist approach" in creating a concise definition of recovery, due to the personal nature of recovery. However, they suggest, "attempts to describe as clearly as we can the concepts underlying recovery and what they would mean in practice are important. Indeed, recent experience in this country suggests that without a degree of 'operationalisation', it is difficult to achieve meaningful service reform" (p.8).

> ***There is no single definition for recovery. It is suggested that this is because recovery is a journey shaped by an individual's own experiences and stages. Key themes identified in defining recovery include that recovery means being able to live a meaningful life, both personally and in the community; redefining a positive sense of identity; making certain life adjustments; overcoming symptoms, stigma and discrimination; and living with hopefulness for the future.***

Townsend and Glasser (2003) explain that *"recovery is what the individual does; facilitating recovery is what the clinician does; and supporting recovery is what the system and community does"* (p.85). Stemming from these distinctions emerge philosophical tensions between the person focus of recovery and the patient, or illness focus of psychiatric medicine (Buchanan-Barker & Barker, 2008, p.94). These tensions can be explored by examining recovery through the following lenses of *clinical recovery* and *personal recovery*, as categorised by Slade, Amering and Oades (2008):

Clinical recovery

Clinical recovery reflects a definition of recovery that has emerged from scientific, clinical literature (Slade et al., 2008, p.130). The medical model drives clinical recovery. It assumes that mental illness is a physical disease, and "recovery" refers to a return to a former state of health. According to this model, mental illnesses are due to a permanent chemical brain imbalance, which is present at birth (Ahern & Fisher, 2001, p.23). An implicit assumption of the medical model is that disease impairs the individual's capacity to make rational choices and thus to act rationally. Another assumption is the notion that patient's perspectives can be rejected as the subjective denial of an objective reality (Lauder, 1999, p.49, 54). The outcomes of recovery from the medical model relate to sustained remission and invariance across individuals. They include reduced symptomatology, hospitalisation and medication use

(Andreson et al., 2003, p.588; Slade et al., 2008, p.129). Little consideration is given to what happens next (Roberts & Wolfson, 2004, p.44).

There are opposing views on whether recovery can occur in a model that requires a return to a former state of health. Critics argue that many consumers may not consider themselves recovered under this definition (Ahern & Fisher, 2001, p.26; Andreson et al., 2003, p.588), and that this view assumes chronicity of psychiatric disabilites (Carpenter, 2002). Proponents for the medical model argue that recovery outcomes, such as reduced symptomatology, are important to recovery orientation (Resnick, 2004, p.540).

The rehabilitation view
The rehabilitation view stems from the clinical notion of recovery that posits that mental illness is a permanent disability, and that people can learn to live within the limitations of disability and their illness (Andreson et al., 2003, p.588; Schiff, 2004, p.215).

Joseph Rogers, a leader of the mental health consumer movement in the United States, aligns himself with this view. He views that recovery is something that can be lost if it is not maintained, and that *"the brain is involved, and biochemistry is involved, and things go whacko"* (Rogers cited in Szegedy-Maszak, 2002, p.55). This suggests that people with the lived experience of mental illness are divided about the lens through which recovery should be viewed.

Personal recovery
Personal recovery reflects a definition of recovery that is individually defined and experienced (Slade et al., 2008, p.130). This model of recovery contrasts to the clinical model of recovery as it is based on a system of health promotion in which individuals actively define their needs and collaborate with others in the healing process (Schiff, 2004, p.214).

It is a view that has been shaped through the accounts of people with the lived experience of mental illness (Deegan, 1988, 1996; Mead & Copeland, 2000) who are "experts by experience" (Roberts & Wolfson, 2004, p.40). An author with the lived experience of mental illness asserts "the recovery movement belongs to consumers-survivors, not to practitioners" (Schiff, 2004, p.212).

The empowerment view
The empowerment model of recovery is based on principles that have emerged from the experiences of consumers in recovery, and challenges the notion of permanent mental illness (Schiff, 204, p.215). These include hope, personhood, self-defined goals, choices, the opportunity for people to speak for themselves, peer support, ending discrimination, self-control of symptoms, well-being, liberty and freedom, and healing from within (Fisher, 1994, p.914).

The empowerment view of recovery suggests that people are born in a relatively balanced state of being. During the course of development people are challenged to adapt to a variety of stressful circumstances, and for some people this can lead to the development of a mental illness. Ahern and Fisher (2001) describe that recovery and restoring emotional balance is facilitated through "an attitude of optimism, understanding, trust, and empowerment" that allows people to retain social roles and avoid being labelled mentally ill (p.26). In this view, a

full recovery is possible for everyone, in conjunction with self-managed care and social supports (Ellis & King, 2003, p.2; Schiff, 2004). Some advocates for the strong version of the empowerment view deny the need for medical treatment (Andreson et al., 2003, p.588).

The psychological view
Andreson, Oades and Caputi (2003) propose a psychological definition of recovery that allows for recovery in the presence of ongoing management of illness. They suggest that their definition falls between the rehabilitative view and empowerment view of recovery. Psychological recovery "refers to the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self determination" (p.588). It places no limitations on the possibilities for people living with mental illness.

There are two models of recovery which are suggested to be in tension with each other:

1) *The medical model drives the clinical view of recovery; recovery is objective and understood to be a return to a former state of health. Outcomes include reduced symptomatology, hospitalisation and medication use.*

2) *The personal view of recovery is driven by people's lived, subjective experiences of mental illness and recovery, and challenges that notion of permanent mental illness. Outcomes include empowerment, hope, choice, self-defined goals, healing, wellbeing and control of symptoms.*

The Mental Health Coordinating Council has elaborated upon this dichotomous view of recovery and proposes that recovery can be further viewed from at least four perspectives. That is, that recovery can be seen as: an experience (of people with mental illness); a philosophy or set of values; an individual (service delivery) practice; and, a service system (response and orientation). These differing views of recovery are further explained below.

The MHCC proposes that recovery can be seen as:

• **An experience**
This conveys the personal and unique journey in recovery from mental health problems. Whilst the individual defines their recovery journey, recovery is not an isolated experience. It occurs within a context where relationships are of utmost importance – family, friends and service providers can share the recovery experience.

• **A philosophy or set of values**
Recovery is fundamentally about a set of values that promote hope, self-determination, inclusiveness, acceptance and compassion. These values all lead to choice and control for people with the lived experience of mental illness.

• **An individual practice**
This refers to how the worker applies their understanding of recovery and recovery principles into action, and how it guides the way in which services and service providers work in partnerships with consumers, carers, families and the community.

• **A service system**
The principles and practices of recovery have broader implications for organisations (culture, structure and leadership), communities, and the wider sector. Recovery provides an opportunity to work together to provide a range of services for consumers and carers, and to ensure better outcomes for consumers and carers.

Source: Mental Health Coordinating Council: "Mental Health Recovery Philosophy to Practice: A workforce Development Guide", 2008, p.15.

5.   Recovery: concepts and facilitators

A review of the literature revealed a number of concepts that interact and facilitate the recovery journey for people living with mental illness. These include taking control of one's own life, understanding one's illness, developing a healthy lifestyle, social supports, nurturing the whole person and social inclusion.

Taking control of one's own life

Individual responsibility
Recovery encourages and requires a person with mental illness to take control and ownership of their life; to take individual responsibility (Ellis & King, 2003; Frese et al., 2001, p.1463; Happel, 2008a). It is about learning how to respond to situations and change, and includes managing medicines, choices, setting goals and taking risks to grow (Andreson et al., 2003, p.588; Sydney West Area Health Service, 2008, p.152). Mead and Copeland describe that:

> *Recovery is a personal choice. It is often difficult for health care providers who are trying to promote a person's recovery when they find resistance and apathy… it is up to each individual to take responsibility for his or her own wellness. There is no one else who can do this for us (2000, p.318, 321).*

Acceptance
Accepting mental illness as a part of a person's life is an essential stage in the recovery process, and includes the process of incorporating the illness and making adjustments (Bullock et al., 2000, p.3; O'Connell et al., 2005, p.379; Mental Health Coordinating Council, 2008; Ridgway, 2001, p.337). Davidson et al, (2006) indicate that people need to "incorporate the illness or disability into their lives as only one part of a multidimensional existence and multifaceted sense of personal identity" (p.644).

Hope
Hopefulness and optimism are central themes in recovery literature, where "hope that leads to recovery is, at its most basic level, the individual's belief that recovery is possible" (Jacobson & Greenley, 2001, p.482). Hope is described as looking forward to the future, the alternative to despair, the perceived ability to meet one's goals and roles in life, a process of healing, and focusing on strengths rather than weaknesses (Andreson et al., 2003, p.589; Deegan, 1996, p.7; Jacobson & Greenley, 2001; Resnick et al., 2004, p.541). Hope is about cultivating positivity in the face of challenges that may arise. As Mead and Copeland outline, "there is hope. A vision of hope has no limits. Even when someone says to us 'you can't do that because you have had those symptoms, dear!' we know it's not true" (2000, p.317).

Identity and empowerment
Striving to build a positive sense of identity is considered important in recovery, concurrent with people having power over their own lives and decisions they make (Deegan, 2003, p.373; Mancini et al., 2005, p.54). Recovery means no longer viewing oneself primarily as a person with a psychiatric disorder and reclaiming a positive sense of self (Ridgway, 2001, p.338). Empowerment has been described as a "process by which individuals with lesser

power gain control over their lives and influence social structures in which they live" (Segal, Silverman, & Tempkin, 1995, p.215). It involves democratic participation in the life of one's community (Rapport, 1987, p.121).

The terms empowerment and identity are also conceptualised through the terms self-efficacy, self-determination, self-redefinition, self-renewal and self-confidence; and are seen as integral components in the recovery journey (see Andreson et al., 2003, p.589; Kelly & Gamble, 2005, p.249; Mental Health Coordinating Council, 2008; Mueser, 2002, p.1273; O'Connell et al., 2005, p. 379; Resnick, Rosenhack, & Lehman, 2004, p.541, Bullock et al., 2003, p.3). Jacobson and Greenly explain that "as consumers reconnect with their selves, they begin to experience a sense of self-esteem and self-respect that allows them to confront and overcome the stigma against persons with mental illness that they may have internalised, thus allowing further connection with the self" (2001, p.483).

Advocacy
Inherent in the concept of empowerment is a person having the opportunity to voice their opinions and concerns. Advocacy is described as "an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments" (WHO, 2003). Advocacy is an extension of taking control of one's life through reaching out to others, and helps people get "what is needed, wanted and deserved in order to support wellness and recovery" (Pathways, 2009). Mead and Copeland reflect from a consumer perspective, "we must advocate for ourselves … it is also much easier if we are supported by health professionals, family members and supporters as we reach out to get our personal needs met" (2000, p.318).

Schiff (2004) recollects how advocacy played an important role in her treatment:

> *Advocating for myself was especially important with medications. I was extremely susceptible to certain side effects and less so to others, so I would research medications and find side effect profiles that would best match my tolerance (p.216).*

Understanding one's illness

Information about mental illness, medication and symptoms
The provision of information to people living with mental illness is requisite to people understanding the cause of their illness, services available, and being informed decision makers in their own treatment (Ellis & King, 2003; Mueser, 2002, p.1274; Resnick et al., 2004, p.541).

Being equipped with ways to identify and manage symptoms is emphasised as a key concept in recovery (Connell et al., 2005, p.379; Deegan, 2003, p.373; Mueser, 2002, p.1273), which may include the use of medication or complementary or alternative treatment.

Recovery can be facilitated through the awareness of alternative therapies and management techniques that encourage stress reduction and relaxation; such as meditation, yoga, acupuncture, visualisation techniques, deep breathing, progressive relaxation, or other hobbies (Mancini et al., 2005, p.53; Mead & Copeland, 2000, p.322). Being able to manage

symptoms without solely relying on medication is reported as potentially beneficial, for example "a focus on learning how to live with auditory hallucinations appears to result in a decrease in their severity and frequency, while simply waiting for the symptoms to disappear leaves a person inactive, isolated, alone" (Davidson et al., 2006, p.642). Creating a plan for managing symptoms in the event of symptom relapse is also acknowledged as useful; as is follow up care from services (Happell, 2008a).

Healthy Lifestyle

Developing a lifestyle that enhances wellness through healthy living assists in recovery. This may include smoking prevention, reduced alcohol and other drug use, maintaining dental care, physical exercise, proper nutrition (which may include limiting foods like caffeine, sugar, sodium and fat) and protection from the sun (Mead & Copeland, 2000, p.322; Pathways, 2009b, West Australian Department of Health, 2004, p.3).

Social supports

The benefits of mutual and supportive relationships to recovery are noted in the literature, which are cultivated through empathy, compassion and rapport (Mental Health Coordinating Council, 2008; Walker, 2006, p.86). The experience of turning towards recovery may come out of the blue, but is more often described as arising from talking to others, particularly to other people with the lived experience of mental illness rather than professionals (Roberts & Wolfson, 2004, p.40).

Social supports foster recovery, and may include relationships with family members, friends, health care professionals and peers (Bullock et al., 2000, p.3; Mancini et al., 2005, p.52; O'Connell et al., 2005, p.379; Pathways, 2009). People with the lived experience of mental illness share that "developing friendships based on love and mutual respect is very important to our recovery" (Deegan, 2006, p.12) and "reaching out for support, connecting with a non-judgmental, non-critical person who is willing to avoid giving advice, who will listen while the person figures out for him or herself what to do" is considered essential (Mead & Copeland, 2000, p.322). For some people who do not fit in, there is a need to join or help form a subculture whose collective voice can provide security and identity (Ahern & Fisher, 2001, p.29).

A study conducted by Young, Green and Estroff (2008) found that collaborative relationships foster recovery, and that clinical relationships must encompass more than medication management. They acknowledge that recovery includes social recovery, including economic and residential independence; the absence of psychotic symptoms and the achievement of well-being and a satisfying life (p.1430).

Peer support presents the opportunity for people to share experiences with others who have the lived experience of mental illness. The role of consumers in helping other consumers, whether as friends or role models, is valued. Schiff outlines "being in hospital with other consumers further motivated my recovery by exposing me to the realities of life with mental illness" (Schiff, 2004, p.213, 216). Peer support can help to validate the notion that recovery is possible (Jacobson & Greenley, 2001, p.485), and "through the use of support groups and building a community that defines itself as it grows, many people find that their sense of who they are expands" (Mead & Copeland, 2000, p.322). People living with serious mental illnesses have formed many groups to help one another with both emotional and practical

issues like employment, housing and insurance (Szegedy – Maszak, 2002).

Nurturing the whole person

Recovery affects every aspect of a person's life, and hence demands a holistic response to mental illness that involves seeing the whole person rather than only the disease (Kelly & Gamble, 2005, p.249; Mancini et al., 2005, p.49). Jacobson and Greenley consider that healing is an important process for recovery (2001, p.483), and for some people spiritual beliefs of one's choice provide an additional source of support that may instil strength and hope to keep working hard in the recovery process (Andreson et al., 2003, p.590; Deegan, 1996, p.12; Nasser & Overholser, 2005, p.126).

The Mental Health Commission of New Zealand (1998, p.15) outlines:

> *Some people believe the origins (or at least the prolonging) of mental illness does not just lie in the person with the illness but the world around them. It may be their family, social injustice, unresponsive services, or a traumatic event. In these cases recovery does not just need to happen to the individual; the people and the systems that contribute to the person's illness also need to change to enable that individual to live a better life.*

Social inclusion

Literature indicates that social inclusion is a central component of recovery, whereby a person's social context must be considered in the maintenance of wellbeing and health.

Social inclusion is about active citizenship and participation; ensuring that people can participate in the economic, social and civic life of the nation (Stephens, 2008). For people living with mental illness, social inclusion includes participation in one's own treatment, participation in service evaluation and advocacy activities (Happell, 2008a; Mental Health Coordinating Council, 2008; Mueser, 2002, p.1273). The importance of participating in creative pursuits is also examined, including "creative and fun activities, doing things that are personally enjoyable like reading, creative arts, crafts, listening to or making music, gardening and woodworking" (Mead & Copeland, 2000, p.322). For Schiff, "music played a remarkable role in my recovery" (2004, p.216).

It also includes access to secure housing, education, training and employment (Andreson et al., 2003, p.590; Mental Health Coordinating Council, 2007 Pathways, 2009). Work and employment have a major role in recovery, bringing financial, social, existential and spiritual benefits (Roberts & Wolfson, 2004, p.44). A study by Provencher, Gregg, Mead and Mueser (2002) found that employment for people living with mental illness was perceived as a source of empowerment and self-actualisation. Young, Green and Estroff explain the benefits of employment:

> *When consumers are employed, symptoms improve; when they hold competitive jobs, self-esteem increases and they participate actively in the social life of the workplace, expanding and deepening normalising relationships (2008, p.1431).*

Greater availability of affordable housing can provide an environment that facilitates better recovery (Carpenter, 2002). Deegan asserts, "of course, permanent, affordable and fully

integrated housing is fundamental to the recovery process" (1996, p.12).

A study conducted by Bullock, Ensing, Alloy and Weddle (2000) found that a psychoeducational leadership program improved recovery for people living with mental illness. In response to the program, participants demonstrated increased feelings of empowerment, self-efficacy, community living skills and reduced symptomatology.

> *Concepts and facilitators of recovery include taking control of one's life through individual responsibility. This includes acceptance of illness, hope for the future, identity and empowerment, and advocacy. Other key concepts important to recovery include understanding one's illness, medication and symptoms; developing a healthy lifestyle; having supportive relationships; nurturing one's whole self and spirituality; and social inclusion in the community, including access to education and training, employment, and accommodation.*

Stages of recovery

Andreson, Oades and Caputi (2003) conceptualise a five-stage model of recovery based on the findings of five qualitative studies (Davidson & Strauss, 1992; Baxter & Diehl, 1998; Young & Ensing, 1999; Pettie & Triolo, 1999; Spaniol et al., 2000).

Their proposed model, which synthesises these studies includes:

1. *Moratorium:* This stage is characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal.

2. *Awareness:* The person has a first glimmer of hope of a better life, and that recovery is possible. This can be an internal event, or a clinician, significant other or role model can spark it. It involves an awareness of a possible self other than that of a 'sick person': a self that is capable of recovery.

3. *Preparation:* The person resolves to start working on recovering. This stage involves taking stock of the intact self, and of one's values, strengths and weaknesses. It involves learning about mental illness and services available, recovery skills, becoming involved in groups, and connecting with peers.

4. *Rebuilding:* In this stage the hard work of recovery takes place. The person works to forge a positive identity. This involves setting and working towards personally valued goals, and may involve reassessing old goals and values. This stage involves taking responsibility for managing the illness and taking control of one's life. It involves taking risks, suffering setback and coming back to try again.

5. *Growth:* This final stage of recovery could be considered the outcome of the recovery process. The person may not be free of symptoms completely, but knows how to

manage the illness and to stay well. The person is resilient in the face of setbacks, has faith in his or her own ability to pull through and maintains a positive outlook. The person lives a full and meaningful life, and looks forward to the future. He or she has a positive sense of self, feeling that the experience has made them a better person than they might otherwise have been.

> **A model synthesising a number of studies by Andreson, Oades and Caputi (2003) proposes a staged model of recovery to be:**
>
> **moratorium on illness → awareness of recovery → preparation to start on recovery journey → rebuilding → growth.**

Recovery models

There are a number of recovery models that are identified in the literature that are used as guiding philosophies in services. These include the Strengths Model, Tidal Model and the Wellness Recovery Action Plan.

The Strengths Model

The six principles of the Strengths Model are:

1. Focus on the person's strengths, not their weaknesses, problems or deficits.
2. Perceive the community as an oasis of resources, not an obstacle to working with a consumer.
3. Interventions are self-determined by the consumer. Nothing is done without the consumer's approval.
4. The case manager to client relationship is primary and essential.
5. Assertive outreach is the preferred mode of intervention, i.e. seeing the client in their home, park or café rather than a practitioners office.
6. People with serious mental illness can continue to grow, to learn and to change.

(Taken from Campbell, 2006, p.43).

Tidal Model

The Tidal Model is a philosophical system and theory for recovery. It was the first such model to be developed by nurses in practice drawing mainly on nursing research. The Tidal Model "focuses on helping people reclaim the stories of their distress and, ultimately, their whole lives" (Buchanan-Barker & Barker, 2008, p.97).

The Tidal Model is based on six philosophical assumptions:

1. A belief in the virtue of curiosity: the person is the world authority on their life and problems.
2. Recognition of the power of resourcefulness. Seeks to reveal the resources available

to the person rather than focusing on their weaknesses.
3. Respect for the person's wishes, rather than being paternalistic.
4. Acceptance of the paradox of crisis as an opportunity.
5. Acknowledging that all of the goals must belong to the person.
6. The virtue in pursuing elegance: psychiatric care can be complex – the simplest possible means should be sought which might move a person forward.

(Taken from Buchanan-Barker & Barker, 2008, p.95).

The Wellness Recovery Action Plan
The Wellness Recovery Action Plan (WRAP) is a self-management and recovery system designed to maintain wellness, decrease symptoms, increase personal responsibility and improve quality of life. It teaches people how to keep themselves well, to be able to identify and monitor symptoms and to use safe, personal skills, supports and strategies to relieve these symptoms. It involves people listing their maintenance activities, personal triggers, early warning signs and an intensive crisis plan (Copeland, 2002).

> ***Identified models that some services use to deliver recovery-oriented services include the Strengths Model, the Tidal Model and the Wellness Recovery Action Plan (WRAP)***

Recovery Tools for Staff and Mental Health Workers

Collaborative Recovery Model
Slade, Amering and Oades (2008) outline that in Australia there has been research undertaken to develop recovery-based service training for workers in the *Collaborative Recovery Model* (CRM) approach to mental health treatment for people with severe and persistent mental illnesses. To date the model has trained over 600 health and community service professionals across Australia. This training was based on the philosophy that people with mental illness have the capacity to lead meaningful and productive lives while continuing to experience significant symptoms of their illness.

Oades, Deane, Crowe, Lambert, Kavanagh and Lloyd (2005) outline that the CRM synthesises evidence-based practices in community mental health contexts with broader evidence based on constructs consistent with psychological recovery.

The guiding principles of CRM include that:

• Recovery is seen as an individual process
• Recovery is enhanced through collaboration and autonomy support.

The components of CRM are:

• Change enhancement
• Collaborative needs identification

- Collaborative goal setting and striving
- Collaborative task assignment and monitoring

Australian Mental Health Work Qualifications and Training

A recent review of mental health work qualifications (Certificate IV and Diploma) in the Australian Community Services Training Package undertaken by the Community Services and Health Industry Skills Council has ensured that nationally recognised recovery oriented training is now available for workers seeking professional development in this important area.

In New South Wales, the Mental Health Coordinating Council works to improve mental health services by promoting and developing the skills, knowledge and qualifications of the community-based workforce, particularly in relation to mental health work. This is done through the delivery of nationally recognised qualifications, including Certificate IV in Mental Health Work and courses specifically to meet the needs of the Community Mental Health Workforce.

Also in New South Wales, The New South Wales Institute of Psychiatry is a major provider of professional education in mental health. Education provided includes consumer, carer and community work programs; and graduate and multidisciplinary postgraduate programs (NSWIOP, 2009).

<u>**Recovery Self-Assessment**</u>

The Recovery Self-Assessment (RSA) was first developed in 2005 at Yale University, following a growing need for a tool to help enhance the recovery orientation of the care provided at mental health facilities. The RSA is an evidence-based tool used to assess recovery plans that have been implemented by mental health service providers to enable consumers in their recovery journey.

A 36-item scale was produced to investigate the degree to which recovery programs are effective. The RSA also identifies strengths of the program and areas for improvement to offer consumer recovery-oriented care.

The RSA contains scale measures that revolve around nine principles of recovery, these are: renewing hope and commitment; redefining self; incorporating illness; being involved in meaningful activities; overcoming the effects of discrimination; assuming control; becoming empowered and more involved in one's community and citizenship activities; managing symptoms; and being supported by others.

The RSA has been developed so that staff, persons in recovery, and significant others may identify practices in their recovery program that facilitate or impede recovery. There are four versions of RSA targeted to different groups, including:

1. Persons in recovery,
2. Family members/advocates

3. Service Providers, and
4. Chief Executive Officers and Directors

The RSA has now been incorporated into various mental health service providers worldwide, with agencies finding the tool helpful in structuring program standards and guidelines.

> ***Identified recovery-based tools for staff and mental health workers to use to enhance recovery oriented service provision include the Collaborative Recovery Model, Australian Mental Health Work Qualifications and Recovery Self-Assessment***

6.   Barriers and challenges to recovery orientation

The following section outlines barriers that present to people living with mental illness at the individual, collective consumer, clinical and systemic level. It should be noted that a pervasive barrier to recovery identified at every level is stigma and discrimination.

Individual level
Barriers to recovery at an individual level include self-stigmatisation, side effects of medication, symptoms of illness, relapse of illness, loss of family and friends, self-esteem and support (Happell, 2008b; Townsend & Glasser, 2003).

Schiff recounts:

> *When we are first diagnosed, we must come to terms with the prevailing ideologies regarding people with mental illness. These ideologies segregate people with mental illness from the rest of the population through the enforcement of an 'us-them' mentality. Consequently, our identity is challenged as we are placed in the 'them' category by virtue of diagnosis (2004, p.217).*

For some people, medication is the key to their recovery, while others describe the debilitating emotional, cognitive and psychiatric side effects of their medications (Mancini et al., 2005, p.51; Slade et al., 2008). Side effects of medications include obesity, diminished sexual function, dry mouth, constipation, extreme lethargy and fatigue, and long term side effects (Mead & Copeland, 2000, p.323).

Deegan recollects:

> *We were told to take medications that made us slur and shake, that robbed our youthful bodies of energy and made us walk like stiff zombies. We were told that if we stayed on these medications for the rest of our lives we could perhaps maintain some semblance of life. They kept telling us that these medications were good for us and yet we could feel the high dose neuroleptics transforming us into empty vessels. We felt like will-less souls or the walking dead as the numbing indifference and drug induced apathy took hold. At such high doses, neuroleptics radically diminished our personhood and sense of self (1996, p.3).*

A consumer who participated in a study (McGrath et al., 2007, p.7) expressed that medication blocked therapeutic opportunities to deal with emotions:

> *…(the drugs) absolutely pushed everything down – everything – because really you are in an altered reality on medication. Absolutely. How can you be honest with anything.*

Schiff reflects:

> *The drugs I was taking caused enormous weight gain, and I was incredibly*

uncomfortable with my physical self (2004, p.217).

It is acknowledged that literature largely ignores the views of consumers of mental health services in relation to medication (McGrath et al, 2007).

Deegan describes a barrier to recovery being the "frenzied saviour response" (1996, p.6). This is when a person's carers, friends and/or family undergo a process of being initially frantic to assist the person living with mental illness, and act in an intrusive and wilful manner. This is followed by a sense of despair and anger directed towards the person living with mental illness when they do not comply with the carer's, friend's and/or family's rationalisations.

> *Identified barriers to a person's recovery at an individual level include self-stigmatisation, the side effects of medication and the "frenzied saviour response" (Deegan, 1996) of a person's family, friend or carer.*

Consumers as a collective group

Barriers to recovery at this level include a sense of hopelessness, stigma and discrimination, and social discourse. Some people with mental illness demonstrate a sense of hopelessness and lack of motivation in their willingness to ask questions and participate in their treatment (Glover, 2005, p.1). This is described in social discourse as when people become engulfed in the "patient role", where a person's identity becomes organised around the role of psychiatric patient, and they become resigned to being the passive recipient of care (Andreson et al., 203, p.587). It is outlined that "too many people have internalised the message that there is no hope, that they are simply the victims of their illness, and that the only relationships that they can hope for are one-sided and infantalising (Mead & Copeland, 2000, p.317).

Stigma and discrimination towards people living with mental illness is a pervasive barrier to recovery (Carr & Halpin, 2002; Cheverton, 2007; Corrigan et al., 2003). Deegan recounts:

> *Our friends were frightened of us or were strangely absent. They were overly careful when near us. Our families were distraught and torn by guilt … slowly the messages of hopelessness and stigma which so permeated the places we received treatment, began to sink in. We slowly began to believe what was being said about us* (1996, p.4).

> *Identified barriers to recovery for consumers as a collective group include when a person becomes hopeless and passive in their care. Stigma and discrimination also hinder recovery.*

Service staff/mental health worker level

There are multiple barriers identified that people living with mental illness may encounter at the service delivery level. These include lack of information, different perspectives on recovery, stigma and discrimination, risk and coercion, and lack of clearly articulated recovery oriented outcomes in services.

Lack of information

Mary Ellen Copeland discusses:

> *I was never told that I could learn how to relieve, reduce and even get rid of troubling feelings and perceptions. Perhaps if I had learned these things and had been exposed to others who were working their way through these kinds of symptoms, I would not have spent weeks, months and years experiencing extreme psychotic mood swings while doctors searched diligently to find effective medications* (in Mead & Copeland, 2000, p.316).

Lack of respect for consumer choice and rights

Mental health services have frequently been criticised for the lack of focus placed by service providers on the values and attitudes deemed important in service delivery by consumers receiving services (Happell, 2008b, p.123). Barriers to recovery, as outlined by mental health consumers, include limited choice in treatment offered by healthcare providers, as well as negative attitudes from healthcare professionals in respect to their rights (Boyd, Aisbett, Francis, Kelly, Newnham & Newnham, 2005, p.4). The views of consumers have been explored in research, with findings suggesting that the rights of the consumer are often ignored (Happell, 2008b, p.124-125). Understanding the rights of mental health consumers has been identified as an important step in their recovery process (Happell, 2008a, p.117).

Different perspectives on recovery

It is documented that health care professionals have different ideas about what recovery is, making it hard to establish genuine recovery oriented services because many believe that they are already working in a recovery framework (Campbell, 2006, p.97). This is exemplified through different goals of consumers, including choice, accessibility, advocacy, equal opportunity, employment, identification of problems, self-help and support; and the goals of service providers, including professional support, treatment and control, including the reliance on using medications (Ellis & King, 2003, p.3; Kelly & Gamble, 2005, p.246; McGrath et al., 2007).

Some staff exploit power imbalances between the professional and the consumer; where the clinician assumes the role of the expert (Mancini et al, 2005, p.51; Walker, 2006, p.83). This corresponds with the clinical view of recovery; a view traditionally used in mental health services (Slade et al., 2008, p.129). It is discussed that service management may have their own agendas, making the implementation of a recovery philosophy difficult, which inadvertently impacts on the quality of service provided to consumers (Campbell, 2006, p.45). A forceful barrier to recovery is the underlying belief among health care professionals that recovery is not possible, and that mental illness is a life sentence to an incurable condition that invariably will only have negative consequences for a person's life course (Rickwood,

2004, p.3). There is presently scepticism of the recovery movement among psychiatrists (Roberts & Wolfson, 2004, p.45).

Mead and Copeland elucidate:

> *Many of us have been told that these symptoms will worsen as we get older. Nothing about recovery was ever mentioned. Nothing about hope. Nothing about anything we can do to help ourselves. Nothing about empowerment. Nothing about wellness … Sometimes our health care professionals are reluctant to assist us in this journey, afraid that we are setting ourselves up for failure* (2000, p.315, 316).

Farkas, Gayne, Anthony and Chamberlin (2005) suggest that evidence-based practice is not always compatible with recovery orientation:

> *Evidence based practice, while able to produce specific outcomes such as reduced symptomatology, decreased hospitalisation, fewer relapses or improved employment, may vary on compatibility with recovery values and ingredients* (p.155).

Literature highlights that while medication is vital as a treatment option for people living with mental illness, an over-reliance on medication as treatment has been detrimental to the functioning of the system (Carpenter, 2002). The findings of a study conducted by McGrath, Bouwman and Kalyanasundaram (2007) highlight the many negative aspects of the drug imperative within the Australian psychiatric system. Findings include that there is pressure for consumers to embrace a drug-based response, non-drug alternatives are not always provided, a lack of information is provided on drugs and side effects, and that the current system does not promote the therapeutic treatment of mental illness. Consumers who participated in the study expressed that medication is only part of the solution, and that there is a need for consumers to have the opportunity to change or cease the use of medication.

Staffing issues
Enduring and collaborative relationships between people living with mental illness and workers facilitate recovery (Young et al., 2008, p.1435). Happell (2008b) presents research findings from Australia that indicate that consumers are not always able to access staff in a timely fashion, and that services are not available all the time. This study also found that consumers failed to establish trust with staff members who did not take them seriously.

Staff training and development
A research team was involved training mental health workers in Australia using the *Collaborative Research Model* (CRM) approach (See Page 29) (Slade, Amering & Oades, 2008). Research relating to the uptake of this training found that while clinicians and support workers had received recovery-based training, this training had not ensured the routine implementation of recovery based practice, with significant difficulties in the transfer of training recognised.

In addition, the authors acknowledge that the practical uptake of recovery-based training was

easier in community mental health organisations than government organisations:

> *Anecdotally, the conceptual and practical uptake has often been easier with the non-government organisations than the government organisations, possibly because the former has had less 'clinical training' which sometimes can be antithetical to the philosophies of self-determination and risk taking* (2008, p.132).

Further exploration is therefore needed to ensure that the training provided in recovery oriented service provision is translated into practice by workers.

Stigma and discrimination in services

Stigma and discrimination at the service delivery level is still apparent (SANE, 2007). Del Veccio outlines how this is perpetuated in service delivery: "we mental health professionals have unwittingly reinforced this devaluation of consumers. Historic practices of sterilisation, psychosurgery, seclusion and restraint, and institutionalisation have undoubtedly resulted in the public's impression that consumers are 'less than other humans "(2006, p.646). Del Veccio goes further in explaining that staff training can encourage the perpetuation of stigma and discrimination: "Provider training, with its primary focus on the deficits of consumers, may promote stigma and discrimination by too often neglecting the resiliencies, competencies, and capacities of those served" (2006, p.646).

Health care professionals are positioned to reinforce poor esteem of consumers by judging their worth through the lens of their disability (Mancini et al., 2005, p.51), and treating people according to their symptoms rather than assessing the treatment needs of the whole person (Happell, 2008b, p.125; Walker, 2006, p.83).

Duty of care, risk and coercion

At a service delivery level, health care professionals' perception of duty of care, and how to balance risk and coercion can create a barrier to recovery. Mead and Copeland discuss that:

> *Many clinicians … worry that stopping the medication will worsen symptoms … people feel that if they question their doctors about decreasing or getting off medications they will be threatened with involuntary hospitalisation or treatment* (2000, p.324).

Accordant with this view, a study by McGrath, Bouwman Kalyanasundaram (2007) found that the perception of danger and risk management sustains the drug imperative among professionals.

It is suggested in the literature that health care professionals are risk averse and err on the side of caution until they are assured that the system will support them in a time of crisis (Meehan et al., 2008, p.180). Paternalism in service delivery has been demonstrated where clinicians prevent consumers from making decisions for themselves and taking part in risky activities such as employment (Mancini et al., 2005, p.51). Risk and coercion are also systemic components of treatment philosophy, and are discussed further in the following section.

Lack of clearly articulated recovery oriented outcomes in services

A barrier to recovery oriented service delivery is the lack of a clearly articulated framework and expected outcomes; there is not clearly prescribed formula or defined set of service inputs for achieving recovery (Meehan et al, 2008, p.178). An obstacle in implementing recovery orientation in practice stems from the difficulty in achieving consensus on a definition of recovery, and also in creating indicators based on a person's unique and personal journey (Shepherd, Boardman & Slade, 2008, p.7).

Dickerson elaborates:

> *As an empirically oriented practitioner, I wonder what the transformed services are that we are meant to be delivering. What are the outcomes that we can measure?* (2006, p.647).

Lakeman argues that current routine outcome measures do not capture the individual differences in wellbeing that underpin recovery orientation. He explains:

> *Concepts such as coping, hope, connectedness, a sense of self-efficacy, empowerment and self-esteem are likely to be far better indicators of recovery processes than psychiatric symptomatology or indeed any kind of rating scale. Unfortunately, whilst more meaningful, these concepts don't lend readily to quantification. They are subjective experiences and defy 'objective' rating (2004, p.212).*

Identified barriers to a person's recovery at a clinical level include a person having a lack of information about treatment options and non-drug alternatives; the clinician assuming an expert role; recovery goals of a person conflicting with those of their clinician; staff attitudes, including lack of hopefulness and stigma and discrimination in services; a lack of respect for consumer choice and rights; the imperative of clinicians to use medication; the lack of access to health care professionals; and staff training that focuses on deficits rather than strengths.

A contentious barrier to recovery is balancing risk and recovery, and it is suggested that clinicians may discourage people from taking necessary risks on their recovery journey.

Systemic level

Systemic barriers to a person's recovery include: traits of the medical model; balancing the duty of care and the need to manage risk effectively for professionals; and ensuring that recovery is applied in practice and not only as rhetoric in policy.

Philosophical tension: Recovery and the medical model

A debate that has emerged around recovery is the apparent clash between the objectivity and scientific nature of the medical model, and the subjective and personally defined qualities ascribed to recovery orientation. These two perspectives, their values and language stand in significant tension with one another, which is represented in Table 1 below (Roberts & Wolfson, 2004, p.40). This tension can be understood by looking through different lenses: the medical model focuses on the disease and pathology of a person, while recovery emphasises a person's potential for growth (Kelly & Gamble, 2005, p.247).

A described barrier to recovery is the objectivity inherent in the medical model that emphasises and reinforces clinician power (Lakeman, 2004, p.213; Walker, 2006) and the concept of chronicity (Carpenter, 2002). Walker (2006) argues that the language of medicine and psychiatry is pathologising and deficit-based, and is used to elevate the professional above the person subject to the labels. He describes the "iron grip of pathologising discourses" that devalues non-dominant cultures and marginalised groups (p.79). As a person with lived experience of mental illness explains:

> *We were coached by professionals to learn to say 'I am a schizophrenic',*
> *'I am a bipolar'… and each time we repeated this dehumanising litany*
> *our sense of being a person was diminished as the disease loomed as*
> *an all powerful* (Deegan, 1996, p.4).

It is identified that diagnoses are value-laden, and are perceived by some to be "life sentences" that can eclipse a person's identity so that, for example, some people with mental illness become "schizophrenics" (Roberts & Wolfson, 2004, p.44). Slade, Amering and Oades argue that recovery discourse can be expected to engender a backlash from professional groups whose power is threatened (2008, p.135).

People with the lived experience of mental illness express that the recovery journey requires a holistic approach to treatment and care. Deegan recollects:

> *The context of our lives were largely ignored. The professionals who*
> *worked with us had studied the science of physical objects, not human*
> *sciences* (1996, p.4).

Consequently it is argued that the biomedical approach is inadequate to address the multi-dimensional nature of the recovery process (Mancini et al, 2005, p.54).

Additional barriers raised include that the medical model does not emphasise people's strengths; it communicates the idea that a good patient is a compliant patient who should follow instructions about medication, accommodation and behaviour; it assumes the chronicity of psychiatric disorders; lacks vocabulary for clinicians to use to capitalise on people's strengths; and defines people according to their symptoms (Carpenter, 2002; Slade et al., 2008; Walker, 2006).

The following table examines the contrasts between the philosophies that underpin the recovery and medical models.

Table 1: **Differences in concepts, language and values between the recovery and medical models**

RECOVERY MODEL	MEDICAL MODEL
Distressing experience	Psychopathology
Biography	Pathography
Interest centred on the person	Interest centred on the disorder
Pro-health	Anti-disease
Strengths-based	Treatment-based
Experts by experience	Doctors and patients
Personal meaning	Diagnosis
Understanding	Recognition
Value-centred	(Apparently) Value-free
Humanistic	Scientific
Growth and discovery	Treatment
Choice	Compliance
Modelled on heroes	Underpinned by meta-analysis
Guiding narratives	Randomised control trials
Transformation	Return to normal
Self-management	Expert care coordinators
Self-control	Bringing under control
Personal responsibility	Professional accountability
Within a social context	Decontextualised

Source: Roberts & Wolfson, 2004, p.40.

Duty of care, risk and coercion

Recovery orientation raises the question of the point at which health care professionals intervene and make choices on behalf of someone living with a serious mental illness, in the instance where that person presents a risk to themselves or others. It is at this point where the possible conflict between legal responsibilities, the Mental Health Act and recovery orientation intersect.

Health care professionals find it challenging to conceptualise risk mitigation within a recovery orientation: "finally providers ask, how can you tell us to promote client choice and self-determination on one hand while holding us responsible for adverse events on the other? Doesn't increasing client choice increase client risk?" (Davidson et al, 2006, p.643).

Frese, Stanley, Kress and Vogel-Scibilia (2001) propose from a clinical view of recovery that:

> *For persons who are so seriously impaired in their decision-making capability that they are incapable of determining what is in their best interest, a paternalistic, externally reasoned treatment approach seems*

not only appropriate but also necessary in most cases for the wellbeing of the impaired individual. However, as these impaired persons begin to benefit from externally initiated interventions, the locus of control should increasingly shift from the treatment provider to the person who is recovering. As individuals recover, they must gradually be afforded a larger role in the selection of treatments and services. Throughout the recovery process, persons should be given maximal opportunity to regain control over their lives (p.1464).

These authors also discern that:

Persons who are very disabled by mental illness are those most likely to benefit from objective, evidence-based approaches to treatment. For these persons there is less of a need to focus on the person-centred principles of the recovery model (2001, p.1464).

Meehan, King, Beavis and Robinson (2008) suggest that a shift to recovery orientation will not eliminate the need for coercion, and may in fact shift coercive roles to other sectors:

Paradoxically, the more health professionals who withdraw from assertive and involuntary treatment in the name of recovery, the more likely that police and others operating outside the mental health system will be called on to assume a coercive role (p.180).

The same authors also indicate that where mental health services operate in the community there is a need for accountability for individual and community safety. This may present as a barrier in the form of low public tolerance for adventurous services (p.178).

Recovery: unrealistic expectations
Some authors argue that a recovery approach "could generate unreasonable expectations or disappointments when recovery as a process becomes confused with recovery as an objective state" (Meehan et al., 2008, p.180). Dickerson, a proponent of the medical model, expresses concern that recovery may generate unrealistic expectations among patients and their families. She suggests this is because, in regards to mental illness, "our science has not come even close to being able to cure or prevent them" (2006, p.647).

Meehan, King, Beavis and Robinson (2008) caution that a shift to recovery orientation may have the impact of devaluing professional help. They suggest that the impacts of this are twofold: one being that people may be discouraged from accessing services that could help them, and the other that clinicians may lose their focus on their role of assisting consumers to achieve functional improvements.

Gaps between policy and practice
Frequently referenced in the literature is the gap between recovery orientation in policy and recovery orientation in practice (Ellis & King, 2003; Happell, 2008a, 2008b; O'Connell et al, 2005, p.378). Rickwood outlines that "commitment at the policy level has not been supported by mental health funding" (2004, p.3).

Numerous Australian policies endorse consumer participation as a necessary component of service delivery and recovery orientation (Commonwealth of Australia 2003; NSW Health 2008), however, there is still a lack of genuine involvement in all levels of service delivery (Glover, 2005, p.2). Tokenistic participation also impedes recovery (Campbell, 2006, p.23).

Identified barriers to a person's recovery at a systemic level include the tension between the medical model (clinical view of recovery) and the subjective nature of recovery (personal view of recovery). Barriers reinforced by the medical model include power imbalances between health care professionals and consumers, the deficit-based language inherent in the medical model, assumed chronicity of illness, and compliance.

Balancing the duty of care and risk management is a challenge identified in providing recovery oriented services. Health care professionals have indicated that risk mitigation necessarily reduces client choice on occasions where people are severely disabled by their mental illness and present a risk to themselves or others.

Further challenges include that the recovery approach may have the impact of devaluing professional help, and that in Australia there still exists a large gap between recovery in policy and practice.

7.   Principles for recovery oriented service delivery

It is acknowledged that the lived experience of mental illness must be synthesised with professional experience to determine how services can best provide recovery oriented services (Glover, 2005, p.2). Themes identified in the literature as principles that should underpin recovery orientation in services include that services:

- Are person-centred (Farkas et al, 2005, p.145; Walker, 2006, p.77). This entails services considering a person's preferences, choices, life goals, and roles in balance with their rights and responsibilities. (Jacobson & Greenley, 2001, p.485; Kelly & Gamble, 2005, p.250; Western Australia Department of Health, 2004, p.13). It includes treatment and planning conducted in a truly collaborative process with personal choice and trust underpinning the relationship (Mead & Copeland, 2000, p.327; Young et al., 2008, p.1434).
- Promote a person's self-determination and individual responsibility (Farkas et al., 2005, p.145; Kelly & Gamble, 2005, p.250; O'Connell et al., 2005, p.379).
- Treat the person with mental illness as an equal (Mead & Copeland, 2000, p.327).
- Understand the person's whole life context (Mead & Copeland, 2000, p.327; Young et al., 2008, p.1434), including consideration of a person's physical health, and alcohol and other drug use, in conjunction with mental illness (Western Australia Department of Health, 2004, p.13).
- Consider and respect a person's culture (Jacobson & Greenley, 2001, p.485; Western Australia Department of Health, 2004, p.13).
- Retain staff whose attitudes and values align with a recovery orientation (Mental Health Foundation of New Zealand, 2008, p.14). This includes that services focus on how the person feels, what the person is experiencing, and what the person wants rather than diagnosis, labelling and predictions about the course of a person's life. It also entails that service providers never scold, threaten, punish, patronise, judge or condescend the person, while being honest about how one feels when a person is threatening or condescending. Of central importance is to ensure that a person's recovery goals are their goals and not those of the service providers (Mead & Copeland, 2000, p.327).
- Emphasise a person's strengths and capacity for growth (Farkas et al., 2005, p.145; Mead & Copeland, 2000, p.327; O'Connell et al, 2005, p.379; Western Australia Department of Health, 2004, p.13).
- Foster hope and empowerment, and use empowering and hopeful language (Jacobson & Greenley, 2001, p.485; O'Connell et al., 2005, p.379; Western Australia Department of Health, 2004, p.13).
- Support community integration and provide links to meaningful activities (O'Connell, 2005, p.379; Western Australia Department of Health, 2004, p.13; Walker, 2006, p.77).
- Provide options for treatment, rehabilitation and support (O'Connell et al., 2005, p.379). This should include sharing simple, safe, practical, non-invasive and inexpensive or free self-help skills and strategies that people can use on their own or with the support of carers, families and/or friends (Mead & Copeland, 2000, p.327). Psychoeducation should be provided to understand illness and treatment, and information should be provided on relapse prevention and coping skills to reduce the persistence of symptoms (Whitley et al., 2009, p.202).

- With a person's consent, recognise and involve carers, families and friends in the stages of a person's recovery journey (O'Connell et al., 2005, p.379; Western Australia Department of Health, 2004, p.13).
- Practice in a manner that is consistent with national standards and regulations (Western Australia Department of Health, 2004, p.13)
- Recognise that the lived experience of mental illness is essential in informing service delivery (Glover, 2005, p.2).
- Are informed by best evidence based practice (Deegan, 2003, p.374; Mancini et al., 2005, p.48
- Facilitate participation in the planning and delivery of services, and advocacy (Farkas et al., 2005, p.145; O'Connell et al., 20005, p.379)
- Challenge stigma and discrimination through accurate portrayals of mental illness (Jacobson & Greenley, 2001, p.485; O'Connell et al., 2005, p.379).
- Protect a person's human rights (Jacobson & Greenley, 2001, p.484).
- Encourage and support connections with others who experience psychiatric symptoms (Mead & Copeland, 2000, p.327).
- Strike a healthy balance between personal growth and risk (Young et al., 2008, p.1434)

Davidson (2008) provides advice on how recovery principles might be conceptualised in application. The following table is an adaptation of the original table.

Table 2: Applied Conceptualisation of Recovery Principles

Recovery principle	What it can mean in practice
Recovery is about building a meaningful and satisfying life as defined by the person themselves, whether or not there are recurring symptoms and problems.	A move away from the focus on the removal of symptoms as the prime purpose of mental health services, towards a focus on the positive aspects of each person's life.
Recovery represents a move away from pathology, illness and symptoms to health strengths and weaknesses.	Staying well and building support structures is important. This may include creating crisis prevention plans and Advance Directives.
Hope is fostered through seeing how to have more active control over one's life, and seeing how others have found a way through.	Having people with the lived experience of mental illness as workers and trainers makes training more real and can lead to cultural change. Training consumers in self management and setting their own agendas when working with professionals becomes important in a achieving a partnership way of working.

Recovery principle	What it can mean in practice
Self determination is encouraged and facilitated, with the acknowledgement that what works for one person may be different to that of another.	Individuals define their own goals and agendas. The role of health care professionals is to help a person achieve these goals in ways and settings that are meaningful and acceptable. Examples include the Wellness Recovery Action Plan (WRAP).
The relationship between professionals and consumers moves away from being expert – consumer and closer to peer support.	The qualities and attitudes of staff become at least, if not more, important than skills and knowledge.
Recovery is closely associated with social inclusion and people being able to participate in the community.	Services provision is guided by the intention to support the individual to use the same resources as the general population.
Recovery is about discovering (or rediscovering) a positive sense of personal identity, separate from illness or disability.	People with the lived experience of mental illness retell their stories in the language of empowerment rather than in a language imposed by others. Discrimination and stigmatisation are tackled directly and assertively.
Language used in relation to mental illness should support empowerment and hope for the future. The language used and the stories and meanings that are constructed around personal experience conveyed in letter, reports and conversations have great significance as mediators of recovery. These shared meanings either support a sense of hope and possibility, or carry an additional weight of morbidity, inviting pessimism and chronicity.	The messages of hope or despair mental health workers give to people are often pivotal in their recovery. Diagnoses can be helpful or very unhelpful. Therapies can empower or disempower. All aspects of services need to be looked at including supervision, induction, workload management, appraisal, 'ward rounds' and partnership working.
The development of recovery based services emphasises the personal qualities of staff as much as their formal qualifications, and seeks to cultivate their capacity for hope, creativity, care and compassion, imagination, acceptance and resilience.	Training should include ways that health service professionals can assist recovery, including active listening, rapid response to need, respect for individual choice and cultural awareness.

Recovery principle	What it can mean in practice
Family and other supports are often crucial to recovery, and where a person with the experience of mental illness consents, should be included as partners to recovery. Peer support is in many cases an important aspect of a person's recovery.	Peer support should be encouraged. Families and other supports should be acknowledged in the development and the delivery of services.

Source: Adaptation from Davidson, 2008

Shepherd (2007, p.6) outlines that the principles of recovery oriented practice need to be spelled out in services. He suggests that there are recovery oriented questions that staff can ask people who present to mental health services which can also be used for evaluation, including:

- Did I promote the person's involvement in their care planning?
- Did I promote their sense of personal control? (i.e. negotiate over treatment and medication options, etc.).
- Did I promote 'hope'? (i.e. maintain high expectations, a sense that key life goals can be achieved, despite the reality of severe mental health difficulties).
- Did I help the person develop methods of self-management? (e.g. give links to useful information sites about mental health problems, treatment, medication and side effects, self-help materials, local self-help and support groups, explore and support personal coping strategies, etc.).
- Did I help the person towards employment options? Did I demonstrate a belief that they can work if they want to? Did I show a willingness to listen to the problems they perceive in getting back to work and advise on how these can be solved?
- Did I ensure that they had stable and safe accommodation, of a reasonable standard, that they are happy with?
- Did I help them access mainstream community activities? (education, leisure, sports, churches, etc.). Am I aware of their existing social networks and want to build on them? Did I talk to them about how to best deal with problems of stigma and social inclusion?

Principles for recovery-oriented service delivery include services that:

- *Are person-centred*
- *Promote self-determination and individual responsibility*
- *Treat people as equals*
- *Are culturally respectful*
- *Emphasise strengths and wellness*
- *Foster hope and empowerment, and use empowering language*
- *Retain staff who work within a recovery framework and have a positive attitude that reflects that recovery is possible*
- *Support community integration and social inclusion*
- *Provide a variety of treatment options*
- *Recognise that lived experience is essential in informing service delivery*
- *Challenge stigma and discrimination*
- *Facilitate consumer participation*
- *Protect human rights*
- *Encourage family and peer support, and acknowledge the benefits*
- *Strike a healthy balance between personal risk and growth*
- *Staff believe that recovery is possible*

8. What needs to happen to make recovery oriented service delivery a reality?

The literature indicates that, while recovery is possible and is facilitated in certain circumstances, there are many ways that the potential for recovery could be enhanced. This section outlines the possibilities for making recovery oriented service delivery realised to a larger extent.

Individual level

Authors with the experience of mental illness identify that in order to recover, people living with mental illness need to be accountable for their behaviour (Deegan, 1996, p.8; Mead & Copeland, 2000, p.326). Deegan also identifies that it is important to "just give everybody the chance to get better and let them go at their own pace" (1996, p. 8).

Mead and Copeland outline:

> *We need assistance, encouragement and support as we work to relieve the symptoms and get on with our lives. We need a caring environment without feeling the need to be taken care of* (2000, p.317).

The narratives of people living with mental illness helps support those on the recovery journey through offering relief of alienation, validation of unusual experience and, when experiences are told in groups, a social context in which coping strategies can be exchanged (Roberts & Wolfson, 2004, p.41). These narratives can help refocus thinking beyond the medical perspective, and serve as strong testaments to recovery and personal growth after the experience of mental illness (Casey, 2008; Ridgway, 2001, p.336, 340). They also continue to be a powerful developer of and source of validation of key ideas and practices (Ramon et al., 2007).

Maximising consumer involvement in all aspects of service delivery is considered essential in being able to set goals and to evaluate progress towards those goals (Fisher, 1994, p.914).

> *To make recovery a reality, individuals need to be accountable for their own behaviour, set goals, go at their own pace and share their recovery stories with others.*

Service and staff level

To be able to facilitate an individual's recovery, services need to reflect the principles of recovery orientation in service delivery. This needs to happen through a shift in service culture towards recovery orientation, a change in staff attitudes, clearly outlined ways to balance risk and recovery, workforce training and development, collaboration between staff and consumers, and benchmarking; which are outlined below.

Shift in service culture towards recovery orientation

The literature indicates that service management are in a powerful position to drive culture, innovation and change, and that this must be informed by clear values and beliefs (Mental Health Coordinating Council, 2008; Whitley et al., 2009, p.208). Staff training and the development of staff attitudes which reflect positivity and hopefulness towards consumers' abilities to set, pursue and attain goals that facilitate recovery are necessary in achieving recovery orientation in services (Oades et al., 2005, p.283). There is suspicion that current services will superficially rebrand themselves without fully addressing the implications (Roberts & Wolfson, 2004, p.46).

It is outlined that recovery is only a part of a much bigger picture of changing cultures and systems that is needed in changing the way that services are provided to people living with mental illness (Campbell, 2006, p.99; Del Veccio, 2006, p.646). Glover suggests that:

> If services are to be influenced by recovery wisdom, then principally a shift in service delivery from a managed care and maintenance orientation to an orientation that embraces self-directed care and self-management will be observed (2005, p.2).

Similarly, Lakeman (2004) recommends that:

> Nursing should align itself with a recovery agenda that stresses the need to develop wisdom, strive towards understanding, and expand our creativity in understanding and responding to people in distress (p.212).

Some authors suggest that empowering staff to believe that they can make a difference, through positive culture change can make a difference in the way that staff practice and conceptualise mental illness (Jacobson & Greenley, 2001, p.484). Whitley, Gingerich, Lutz and Mueser (2009) indicate that cultural change can be effective when staff members feel valued:

> Staff members who feel valued by their agency, and an organisational culture that embraces change and is not overly averse to risk, may facilitate the implementation of a new practice, despite the uncertainties of long-term funding and fiscal support for that practice (p.208).

Robertson and Wolfson (2004) suggest that a change in the role of the psychiatrist is required, from someone who is perceived as a remote expert or authority to someone who behaves more like a coach or personal trainer, offering professional skills and knowledge, while learning from and valuing the person living with mental illness (p.41).

Shepherd, Boardman and Slade envisage that a practical way to assist in the implementation of recovery practices into services would be to create a "Policy Implementation Guide" to provide simple guidelines for practice at a individual, team and service level (2008, p.13).

Consumer participation at all levels of service delivery

Literature identifies that consumer participation is important as a part of recovery, and involves an individual actively participating in choices that affect the services that they

receive. By working in a collaborative relationship with service providers, people living with mental illness can work together to plan, negotiate and make decisions about the services and activities in order to support his or her recovery (Jacobson & Greenley, 2001, p.484). In addition, an integral component of consumer participation is recognised to be participation in the evaluation of mental health services. However, consumer participation at this level in Australia is identified to be tokenistic and not sufficiently supported to be effective (Happell, 2008b).

The Australian *National Mental Health Policy 2008* highlights that "It is important that people with mental health problems and mental illness have a significant say in their individual treatment, and, more broadly, in how the mental health system is organised and run" (Commonwealth of Australia, 2009, p.11).

 The New Zealand Mental Health Commission outlines:

> *The recovery approach cannot happen without service user participation… A recovery approach recognises and develops service users' ability to participate actively in learning to live well in the presence or absence of their mental illness. This includes reclaiming one's voice in every area of life, including the experience of mental health services* (2002, p.14).

A study by Kidd, Kenny and Endacott (2007) presented the findings that infrastructure needs to be available in services to support consumer participation initiatives, and that this needs to overcome the identified barrier of staff failing to understand the value of what consumers can offer a service.

Workforce training and development
Training and development is viewed as a facilitator of cultural change. Fisher (2001) elucidates "there needs to be a cultural shift towards people rather than pills to alleviate this form of human suffering". Rickwood explains:

> *Workforce training and development is fundamental to the rollout of a recovery orientation. All sectors of the mental health workforce need to be trained to enable them to operate within a framework that supports the empowerment of consumers and personal capacity building* (2004, p.3).

It is identified that a component of staff training should focus on being able to coherently communicate about recovery (Meehan et al., 2008, p.181), and to see people with mental illness as people who need help rather than objects in need of repair (Fisher, 1994, p.915).

Staff attitudes
The literature outlines that health care professionals play an instrumental role in facilitating recovery; that recovery orientation in services lies in the attitudes, knowledge and skills of the professionals who provide them (Farkas et al., 2005, p.153; Jacobson & Greenley, 2001, p.485; Mancini et al., 2005, p.54).

Glover (2005) suggests that a change in staff attitudes is required to overcome stigma and discrimination, while Rickwood (2004) indicates that a change in staff attitudes is fundamental to working in a recovery orientation. Consistent with this view is that service providers:

> *Should seek to leverage their services to promote the components of recovery highlighted by patients. This will require mental health staff to approach service provision with new thinking, refined skills and more positive outcomes.* (Meehan et al., 2008, p.178).

A service provider outlines,

> *As providers, we should adopt an attitude of optimism and strive to facilitate patients' achieving competence, independence and personal fulfilment (Dickerson, 2006, p.647).*

Glover (2005) highlights that service providers need to believe unconditionally in a person's ability to recover, and reflect whether services are in fact inhibiting individual recovery processes. It is essential that services consider the whole person and not only their disease (Kelly & Gamble, 2005, p.249; Mancini et al., 2005, p.54).

Mead and Copeland advise that health care professionals "need to look at our willingness to recover and not perpetuate the myth that there is a big difference between themselves and people they work with" (2000, p.316).

It is recommended that:

> *Providers must embrace the belief that every consumer can achieve hope, healing empowerment, and connection, no matter what his or her current status. The belief must lead them to focus on the person, not the illness, and on his or her strengths and goals* (Jacobson & Greenley, 2001, p.484).

Clearly outlined ways to balance risk and recovery
A challenge to recovery orientation is risk assessment and management. In situations where a person presents a risk to themselves or others, services need to be able to balance the tension between working with the priorities and goals of consumers, and addressing the expectations and anxieties of the community and the legal responsibilities of the professionals and service (Meehan et al, 2008, p.181).

Davidson, O'Connell, Tondora, Styron & Kangas (2006) explain that in cases where people present risk to themselves or others:

> *The issue of informed consent and permission to treat is suspended temporarily to perform life-saving measures. These cases do not contradict recovery but pose important challenges to it – challenges that may in the future be addressed through such mechanisms as psychiatric advance directives or other creative means to enable people to regain control of their lives, even in such extenuating circumstances... we*

*suggest that there it is more useful to highlight the ways in which a recovery-approach clarifies and reinforces the need that already exists for appropriate risk assessment and management (*p.644).

These authors contextualise that:

Although a recovery orientation might in fact increase risk, it is primarily the person's access to opportunities for taking risks that needs to be increased, not necessarily the provider's or community's exposure to risk (p.644).

Mead and Copeland (2000) express that for people on the recovery journey, taking risks with the support of health care professionals is a necessary component of the journey:

It must be recognised that risk is inherent in the experience of life. It is up to us to make choices about how we live our lives; it is not up to health professionals to protect us from the real world. We need our health care professionals to believe that we are capable of taking risks and to support us if we take them (p.325).

Roberts and Wolfson (2004) identify that some people associate being well with giving up medication, even when there are adverse consequences. They suggest that work between health care professionals and people with mental illness must examine risks that can be taken in safe parameters and lessons learned from experience. They elaborate that:

Such negotiation and choice should be based on a well-informed and thoughtful search for the most effective medication in the lowest dose and include recognition that, for some, the experience of taking medication can be worse than the disorder. It also needs to be acknowledged that it is possible for some to recover and stay well without medication, but there is no reliable way of knowing who will remain well (p.42).

Shepherd, Boardman and Slade suggest that it is important to identify who carries the risk in the relationship between the health care professional and the person living with mental illness:

Most risk is actually shared and everyone involved should be clear about what risks they are carrying. If an individual chooses to ignore clearly documented professional advice then they carry the risk. If a professional commits an act which clearly contradicts their 'duty of care', then they are responsible. Either way, the risks are not being appropriately managed. It is certainly not helpful if professionals things that they carry the sole responsibility for how people live their lives (2008, p,7).

Collaboration between staff and consumers
The need for collaboration between staff and consumers is identified in the literature as being requisite to recovery orientation. A collaborative relationship is defined as being "one in which both consumer and provider come to see each other as human beings" (Jacobson & Greenley, 2001, p.484). Collaborative relationships are beneficial as they allow consumers and patients to work together with accountability, choice, mutual assumptions of responsibility, particularly fostering self-responsibility for consumers, and power sharing (Anthony, 1993; Dickerson, 2006; Jacobson & Greenley, 2001; Mead & Copeland, 2000). This also encompasses providing the services that consumers require, including access to support services, vocational and employment opportunities, and options for social inclusion (Kelly & Gamble, 2005, p.250; Rickwood, 2004, p.3).

Person-centred care involves services empowering consumers to take control and be the primary decision-maker in relation to their own treatment, care and goals for recovery; where self-directed care is the ideal situation where a consumer has the ability to self direct their care and self manage. For services to be oriented towards person centred care, service providers need to value the inclusion of the consumer and acknowledge that they are central to all planning processes (Glover, 2006).

It is suggested that for genuine collaboration to occur, the treatment for people living with mental illness needs to be reframed from the professional's perspective to the person's perspective. In this context, the issue is not what role recovery plays in treatment, but the role that treatment plays in recovery (Davidson et al, 2006, p.643).

Benchmarking
It is suggested that benchmarks need to be created as a way to evaluate the degree to which a service is recovery oriented. Benchmarks will need to consider the lived experience of recovery in addition to service characteristics (Meehan et al., 2008, p.179).

Strengthen the evidence base and research methods
The need to gather and strengthen the evidence base for recovery suggests a major area for collaboration between people with the lived experience of mental illness and service providers. There also remains a need to develop research methods that integrate the relevance of subjective accounts with the rigour of reproducible objective measures (Roberts & Wolfson, 2004, p.41).

The lived experience of mental illness must inform service delivery
It is identified that the lived experience of mental illness of those who have struggled and triumphed over mental illness must inform service delivery (Glover, 2005, p.2). Recovery oriented services need to centre staff training on the lived experience of people who use the services (Roberts & Wolfson, 2004, p.43).

The future of recovery oriented service delivery demands a much greater awareness of recovery processes and the lived experience of mental illness (Meehan et al., 2008, p.179).

> **To make recovery a reality, services need to experience a cultural shift to embrace self-directed care and conceptualise mental illness in a way that can foster hope and empowerment for a person's recovery, and value people living with mental illness. This needs to be a component of workforce training and development.**
>
> **Consumers need to be involved in consumer participation at all levels of service delivery, and staff must recognise the value of consumer input in the improvement of services.**
>
> **Staff attitudes must align with recovery orientation principles, and the belief that recovery is possible.**
>
> **It is important that options for choice are made available, where possible, in situations where people are unable to make decisions due to illness or incapacity through mechanisms such as crisis prevention planning and Advance Directives.**
>
> **Services need to be able to work collaboratively with consumers to support a person's risk taking and personal growth, where this risk taking does not increase a person's risk to themselves or the community.**
>
> **Services need to appreciate the validity of people's personal experiences of mental illness in informing service delivery.**
>
> **Future directions for service delivery should include appropriate benchmarking around recovery indicators, strengthening the evidence base for recovery and future research into recovery.**

Systemic level

Awareness of mental illness

Increased awareness around mental illness is vital in reducing persistent stigma and discrimination towards those with the experience of mental illness. Recovery needs to be viewed as a normal human process, and people who live with mental illness need to be accepted as human beings, by both health care professionals and the general public (Davidson et al, 2006, p.643; Deegan, 1996, p.2; Mental Health Coordinating Council, 2008). This underscores the idea that all people have a shared humanity that should be celebrated (Del Veccio, 2006, p.646).

There is a need to acknowledge that recovery does happen, and that people who experience psychiatric symptoms can and do get well (Andreson at al., 2003, p.587; Davidson et al., 2006, p.642; Kelly & Gamble, 2006, p.247; Mead & Copeland, 2000, p.317).

Reducing social stigma is crucial to recovery orientation, and will help reduce the internalised stigma that some people living with mental illness may hold towards themselves, and increase levels of social inclusion (Jacobson & Greenley, 2001, p.484; Kelly & Gamble, 2005, p.250). This is important in employment; that the life experience of recovery is viewed as an asset in hiring, not a liability (Fisher, 1994).

Anti-stigma and educational campaigns may focus on dispelling myths about mental illness and making the community aware that people living with mental illness can overcome their illnesses and participate fully in their communities (Del Veccio, 2006, p.646). Successful anti-stigma programs include the *Like Minds, Like Mine* program in New Zealand (New Zealand Ministry of Health, 2007; Vaughan & Hansen, 2004) and the *See Me* campaign in Scotland (Myers et al, 2009).

Consumer participation
It is identified that recovery for people living with mental illness can be facilitated through active citizenship, including social and economic opportunities for participation (Mental Health Foundation of New Zealand, 2008). The United Nations *Convention on the Rights of Persons with Disabilities* highlights that consumer participation is a human right that needs to be manifested in a myriad of situations, including:

- Article 19 recognises the rights of people with disability to live independently and be included in the community;
- Article 24 addresses the right to education;
- Article 26 addresses the right to habilitation and rehabilitation, including peer support; and
- Article 29 addresses the right to participation in social and public life.

Australia's *National Mental Health Policy 2008* acknowledges the right and importance of participation for people living with mental illness in access to full social, political and economic participation in their communities, with a particular emphasis on housing and employment (Commonwealth of Australia, 2009).

Shepherd, Boardman & Slade suggest a tenet of recovery is participation, which is widening the scope of preferred outcomes for a person living with mental illness:

> *Housing, employment, education and participation in 'mainstream' community and leisure activities then become the central objectives, not just things that professionals hope will happen if the person is 'cured'. Treatments, whether physical, psychological or social, are useful only insofar as they assist with these aims. This turns the traditional priorities of mental health services 'upside down* (2008, p.4).

Language associated with mental illness
Language that is used to describe mental illness in a paternalistic manner can impede recovery. It is suggested that the language of the medical model needs to be changed from being pathological and deficit-based, to being language that engenders understanding, hope and empowerment (Glover, 2006; Kelly & Gamble, 2005, p.250).

An example raised by the Mental Health Coordinating Council is the phrase "case management" that carries negative connotations that are in conflict with the principles and intent of recovery. It is suggested that language always needs to be sensitive to the individual person, with service providers consulting with a person about their preferred language (for example, whether a person prefers the term consumer, client, member, service user, provider) (2008, p.49). It is important make no assumptions about how someone prefers to be described (Disability Education Association NSW/ACT Inc., 2004).

Recognition of human rights
Jacobson and Greenley (2001) indicate that recovery orientation is founded upon human rights principles, which must be upheld for recovery to become a reality. They suggest that this entails:

> *Reducing then eliminating stigma and discrimination against persons with psychiatric disabilities; promoting and protecting the rights of persons in the service system; providing equal opportunities for consumers in education, employment and housing; and ensuring that consumers have access to the needed resources, including those necessary for sustaining life (adequate food and shelter) as well as the social and health services that can aid recovery (physical, dental and mental health services, job training, supported housing, and employment programs* (p.484).

To make recovery a reality at a systems level there needs to be a greater awareness of mental illness, and a determined effort to eliminate stigma and discrimination. A greater awareness of human rights in the community needs to support this.

Consumers need to be able to participate at every level of the mental health system, and more broadly society.

The language that is used to describe mental illness needs to shift from being deficits-based, and be reframed to engender hope and empowerment.

Table 3 provides examples of the changes needed in services to make recovery oriented service provision a reality.

Table 3: Overview of Recovery Oriented Practice Changes

		TRADITIONAL SERVICES	RECOVERY-ORIENTED SERVICES
		←Continuum→	
BELIEFS	**View of madness**	Pathology No meaning	Crisis of being Fully human experience
	Philosophy	Treatment Paternalism	Recovery Self-determination
	Language	Medical Objective "They"	Personal Subjective "We"
CONSUMERS	**Service users**	Passive recipients	Active agents and leaders
	Families	Unsupported and grieving	Supported and supportive
	Workforce	Mainly medical/clinical Expert authorities	Diverse backgrounds Collaborators
	Communities	Fearful and discriminatory	Accepting and inclusive
SERVICES	**Service types**	Drugs and hospitals	Broad range of therapies; supports; recovery education; and advocacy
	Service cultures	Authoritarian Segregation from society	Participatory Inclusion in society
	Service settings	Hospitals and clinics	Community and home based crisis and other services Online services
OUTCOMES	**Social networks**	Service community	Natural community
	Housing	Hospitals Residential services	Own home
	Employment	Pre-vocational services Sheltered workshops Unemployment	Real work for real pay A valued contribution to society

Source: *Destination Recovery,* Mental Health Foundation of New Zealand (2008) p. 49.

9.   Case Studies

The following case studies provide examples of recovery models that have enhanced recovery oriented service provision in practice.

St Vincent's Mental Health Service, Melbourne – The Strengths Model

St Vincent's Mental Health adopted the Strengths Model with the aim of identifying and promoting the strong points of the individual and using them to promote a greater sense of hope and control. Stemming from the model, case managers at St Vincent's Mental Health encourage consumers to consider, identify and work towards achieving personal goals as part of their recovery.

The implementation of the Strengths Model began in 2004 when it was identified that there was a need for a model of care which was consistent with the key recovery principles. A Rehabilitation Working Party (RWP) was established with multidisciplinary representation including the Director of Clinical Services and the SVMH Manager, as well as relevant managers, psychiatrists and senior clinicians from relevant services in the area (Chopra et al., 2009). The Strengths Model was selected by the RWP for its emphasis on focusing on the goals of the individual and the potential for it to be fully integrated into everyday clinical practice (Chopra et al., 2009, p.204).

The next step for SVMH involved correspondence with Timaru Psychiatric Services in New Zealand, which was identified as a clinical service with expertise in its implementation. In the hope of exporting its practice, a group of senior clinicians, managers and psychiatrists from SVH flew to New Zealand for training by Timaru Psychiatric Services over a one week period. The model was then implemented into mental health services which were identified as providing an 'intensive' rehabilitation, which included the Footbridge Community Care Unit (CCU) and the Mobile Support Teams (MST). Finally, training workshops were developed based on the training modules, which had been provided by the Timaru Psychiatric Service, and provided to all clinicians at the CCU and MSTs.

Chopra et al (2009, p.204) acknowledge that the top-down support of implementation of the Strengths Model by the Director of Clinical Services, the Academic Head of Department and the SVMH was vital in ensuring that the process of implementation was consistent and accepted by all clinicians and managers as a key future direction for the service.

The Strengths Model has now been implemented to the SVMH 2008-2011 Strategic Plan (Chopra et al 2009, p.204), and has been disseminated across the continuum of the service.

The 'Flourish' program – A recovery based self-development program founded on positive psychology principles

The Flourish program is a self-development program for people recovering from a long-term mental illness. The program is unique in that the focus is on the positive and working towards the future, rather than focusing on problems.

Flourish was designed by a team at the Illawarra Institute for Mental Health at the University of Wollongong, and has been trialled at a number of locations in NSW.

Flourish focuses on the positive and working towards the future, rather than focusing on problems. It is called a 'self-development' program because it is designed to enable people to take responsibility for making the positive changes they want to see in their lives. In that way, it encourages personal growth. *Flourish* is based on the principles of the positive psychology movement, which advocates that more effort should be invested in studying what makes people thrive, rather than focusing solely on what makes things go wrong. The concept of 'flourishing' holds that symptoms of mental illness do not preclude living a fulfilling and meaningful life, while the lack of symptoms does not guarantee a flourishing life (Keyes, 2003).

While Flourish is sensitive to the unique challenges that a person with a serious mental illness faces, it also acknowledges that everyone has a core self that strives to learn, grow and thrive. This core self is represented by a set of deeply held values that steer the person in the life journey.

The program has modules covering recovery and 'flourishing'; identifying strengths and values clarification; life vision and goal planning; how positive emotions can help us to grow; how 'mindfulness' can help us deal with anxiety; the process of change and overcoming resistance to change; and obtaining social support for goals.

Feedback from those that have finished the program is that the positive focus was very welcome and 'just what is needed'. Interviews with some of the participants have shown that individual people gain more from different parts of the program. The researchers are very pleased with the results so far, and are hoping to obtain funding to expand the program and to make materials available online for the future.

Ruah Inreach's WRAP Program

Ruah Inreach's Wellness Recovery Action Plan (WRAP) program focuses on providing consumers support from individuals with the lived experience of mental illness. WRAP is a self management program, allowing consumers the opportunity to develop strategies to effectively manage their illnesses and achieve their life goals (Morrow, 2008, p.1).

Ruah Inreach started an initial WRAP Pilot Program in October 2003. Over the following years trials were conducted and Ruah Inreach conducted a facilitation course and delivered a WRAP course in Western Australia (WA) in 2005. Since 2003, around 70 people have now completed the course.

The WRAP program is now run in many areas across WA in collaboration with mental health services and community agencies, run as an eight week program, including a follow session with members of the group one month after completion. Follow up sessions form the basis of an ongoing peer support program, allowing WRAP participants to keep moving forward in their recovery journey.

Ruah Inreach's program was created with assistance from the consumer movement, facilitated jointly by a mental health consumer and a mental health worker. Ongoing collaboration with consumers has been crucial for the success of WRAP, utilising their skills, knowledge and experience. Through a consultative process, Ruah Inreach has been able to plan and develop infrastructure which supports the sustainable delivery of the program.

Participants who have taken part in WRAP have recorded an extremely positive change over the course of the program. Feedback included higher levels of self-esteem; increased confidence when advocating to have their needs met; increased positive thinking; communicating more assertively; beginning volunteer work; and the development of facilitation skills (Morrow, 2008, p.3).

WRAP is successful due to the program being consumer developed and consumer driven. Consumers are able to provide their experiences and wisdom, sharing their stories in an atmosphere of hope. The program encourages participants to take responsibility for their wellness; educate themselves about their condition; advocate around their needs; and increase more supportive networks.

Rangipapa Mental Health Service - Tidal Model

The Tidal Model was introduced into Rangipapa Mental Health Service (RMHS), a regional mental health facility in New Zealand, in 2000. The model was introduced as a method of guiding the practice of mental health nurses to facilitate a high level of engagement with consumers. The Tidal Model exists on the basis that a person's narrative is central to assessment, care planning and documentation. Through the focus on narrative, nursing staff are able to personalise care for the individual based on their life story (Cook, Phillips & Sadler, 2005, p.537).

Strong emphasis has been placed on the interaction between the nursing staff and the consumers, with nurses regarding the consumer as an expert in their own lives, which in turn has enhanced therapeutic outcomes.

The Tidal Model at RHMS focuses on five themes, they are:

1. Hope – an installation of hope is the first and most important factor for consumers experiencing a mental illness
2. Levelling – achieved through a change in the interpersonal control, where consumers are accepted as active participants in their own recovery by health care professionals
3. Relationships – achieving a unique connection between the nursing staff and the mental health consumer
4. Working together – creating a shared endeavour by nursing staff and consumers working together to reach the common goal of the consumer's recovery
5. Human face – bringing humanity to the recovery process, and providing a humanistic framework that makes consumers feel a sense of their importance

The Model has also recommended that consumers should be involved in accessing their own resources, such as family in their recovery journey (Barker & Buchanan-Barker, 2005).

The collaborative activity whereby nurses and consumers together uncover the person's story through the use of narrative has been appreciated as a very personal and consequently, a validating process. With RHMS allowing consumers strong personal control over their treatment, they have also reported a stronger feeling of real control and freedom, as well as staff reporting back a high level of engagement in the recovery process (Cook, Phillips & Sadler, 2005, p.539-540).

Nursing staff have also given positive feedback on the Tidal Model at RHMS. Nurses have reported that the model has supported their nursing practice in such a way that has allowed them to develop effective therapeutic relationships. Further, nursing staff have reported increased professional satisfaction following the implementation of the model.

Through a high level of engagement from both nursing staff and mental health consumers, the Tidal Model at RHMS has been considered to achieve critical success (Barker & Buchanan-Barker, 2005, p.222).

10. Recommendations

This literature review identifies key points that can be used to guide the creation of a recovery resource for mental health community sector organisations in NSW. The recommendations below are intended to provide direction for further consultation with consumers and service providers within mental health community sector organisations in NSW in relation to the development of a resource to support the sector in recovery oriented service provision.

Defining recovery

The literature identifies a strong need for services to have a concrete definition of recovery to draw on in practice. However definitions of recovery are not concrete in nature and are shaped by individualised definitions in order to make recovery meaningful and useful to the individual. This suggests that there may be a need to provide concrete concepts surrounding recovery to guide services in practice, whilst leaving room for consumers to define their own concepts of recovery to aid their own personalised journey.

In attempting to define recovery much of the literature draws on individual story telling to capture this complexity. It is recommended that this may be resolved by providing a definition within the resource, followed by individual case studies and stories to try and capture the broader complexity of the definition.

This review has found that the Anthony (1993) definition of recovery is pervasive in both literature and policy. However, it is essential that consumers have input into a recovery definition. As a basis for consultation, this review identifies that key themes in defining recovery include that recovery means being able to live a meaningful life, both personally and in the community; redefining a positive sense of identity; making certain life adjustments; overcoming symptoms, stigma and discrimination; and living with hopefulness for the future. It needs to be acknowledged that recovery means different things for different people, and that it can be viewed as both a process and an outcome.

Recommendation 1: Include a broad definition of recovery in the resource in order to operationalise recovery concepts in practice.

Recommendation 2: Further consult with stakeholders, including consumers, service providers and carers to create a definition of recovery to guide the resource.

Recommendation 3: Acknowledge in the resource that recovery means different things to different people: consumers, their families, carers, service providers and the wider community. As such the resource could be written to support these different roles and functions.

Actions/support that facilitate the recovery journey

The literature identifies that there are a many ways that recovery can be realised in practice such as taking control of one's life through individual responsibility, understanding one's illness, supportive relationships, nurturing one's whole self and spirituality and social inclusion in the community, including access to education and training, employment and education.

Recommendation 4: Identify in the resource ways that recovery can be facilitated. This could be presented through case studies and/ or examples of what has helped people along their recovery journey.

Barriers to recovery

The literature identifies that there are numerous barriers preventing the realisation of recovery oriented service delivery in practice. These barriers occur on a number of levels.

Recommendation 5: Identify in the resource barriers presented at the individual level, the clinical level and the broader community level, and present strategies and/or resources for overcoming these barriers.

Principles of recovery

Key principles to guide recovery oriented service delivery are outlined in this review.

Recommendation 6: Outline in the resource key principles of recovery oriented service delivery, based on the principles outlined herein and further consultation.

Models and programs

This review identifies that there are numerous models and programs used in practice to implement recovery oriented service delivery. These include the Strengths Model, the Tidal Model, the Wellness Recovery Action Plan and the Flourish Program.

Recovery-based tools for staff and mental health workers

This review identifies tools for staff and mental health workers to use to enhance recovery oriented service provision. Some of these include the Collaborative Recovery Model, Australian Mental Health Work Qualifications and Recovery Self-Assessment.

Recommendation 7: Identify in the resource successful models of recovery oriented service delivery that have been used in practice.

Service culture

Literature indicates that a shift in service culture is necessary to support and fully realise recovery orientation in practice. It is identified that important factors in change include the acquiescence of service management to working within a recovery orientation, and staff attitudes and language use that support recovery. It is acknowledged that tools to facilitate this change include workforce training and development, such as the Collaborative Recovery Model.

Recommendation 8: It may be useful in the recovery resource to:
- Identify potential tools to support a shift in service culture towards recovery oriented service delivery.
- Further investigate the role of service leadership and management, and what is required to support their acquiescence to recovery orientation in practice.
- Further investigate the impacts of staff attitudes and language use, and how these can best support recovery orientation in practice.

Culturally and Linguistically Diverse Communities

The literature shows that different cultures conceptualise recovery differently. This needs consideration when developing a recovery resource for mental health community sector organisations.

Recommendation 9: Consider in developing the resource that different cultural conceptualisations of mental illness exist.

Future directions: making recovery a reality

There are a number of issues raised in this review that are beyond the scope of this project, but are important to recognise as identified areas for further work to make recovery orientation a reality. These include:

- That stigma and discrimination towards people living with mental illness is pervasive, and overcoming this requires a cultural shift towards accepting recovery orientation in services. The greater acceptance of mental illness in the wider community would also help reduce stigma and discrimination.
- Creating benchmarks around recovery indicators across mental health community sector organisations.
- Strengthening the evidence base and research around recovery.

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