

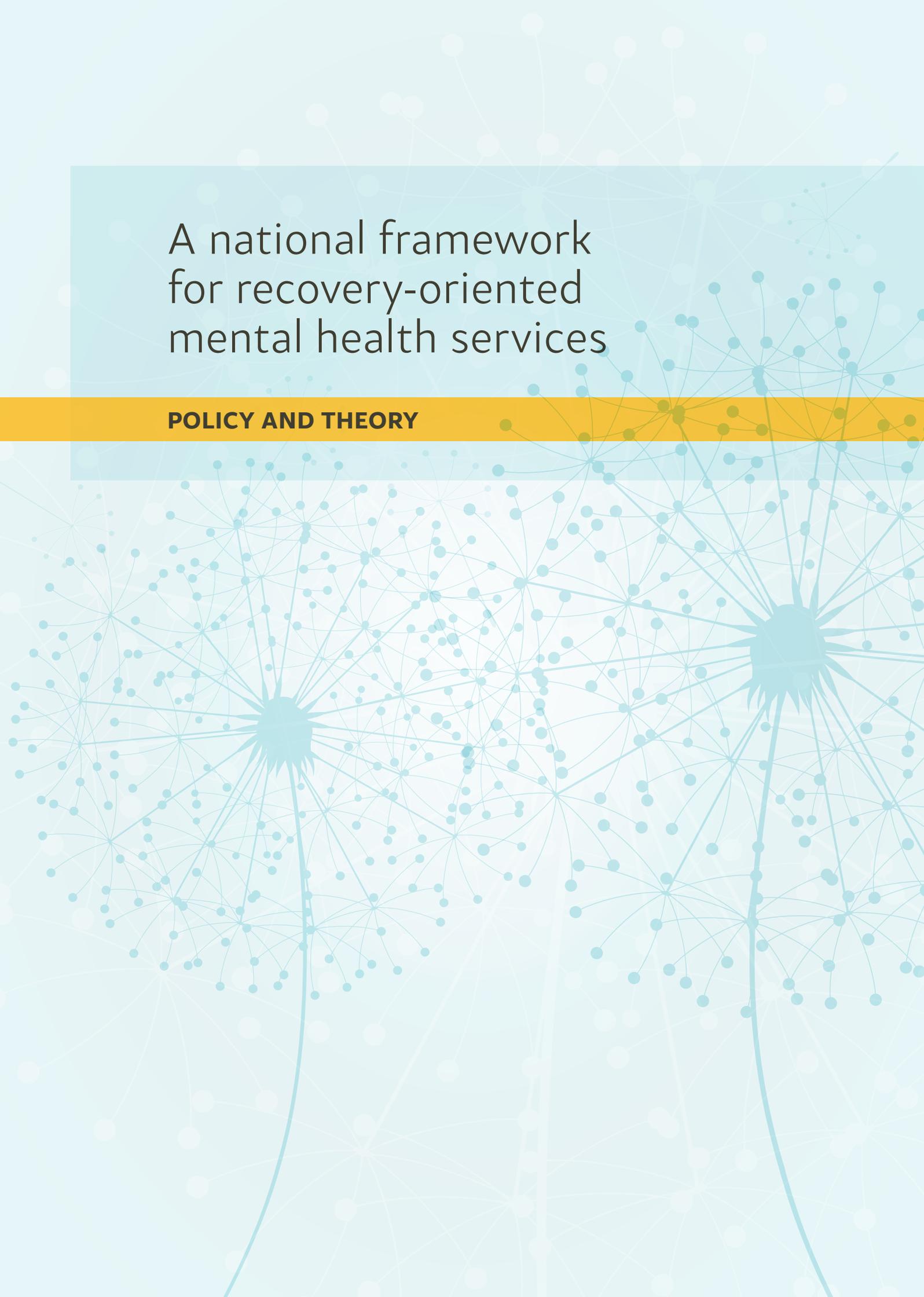
A national framework for recovery-oriented mental health services

POLICY AND THEORY



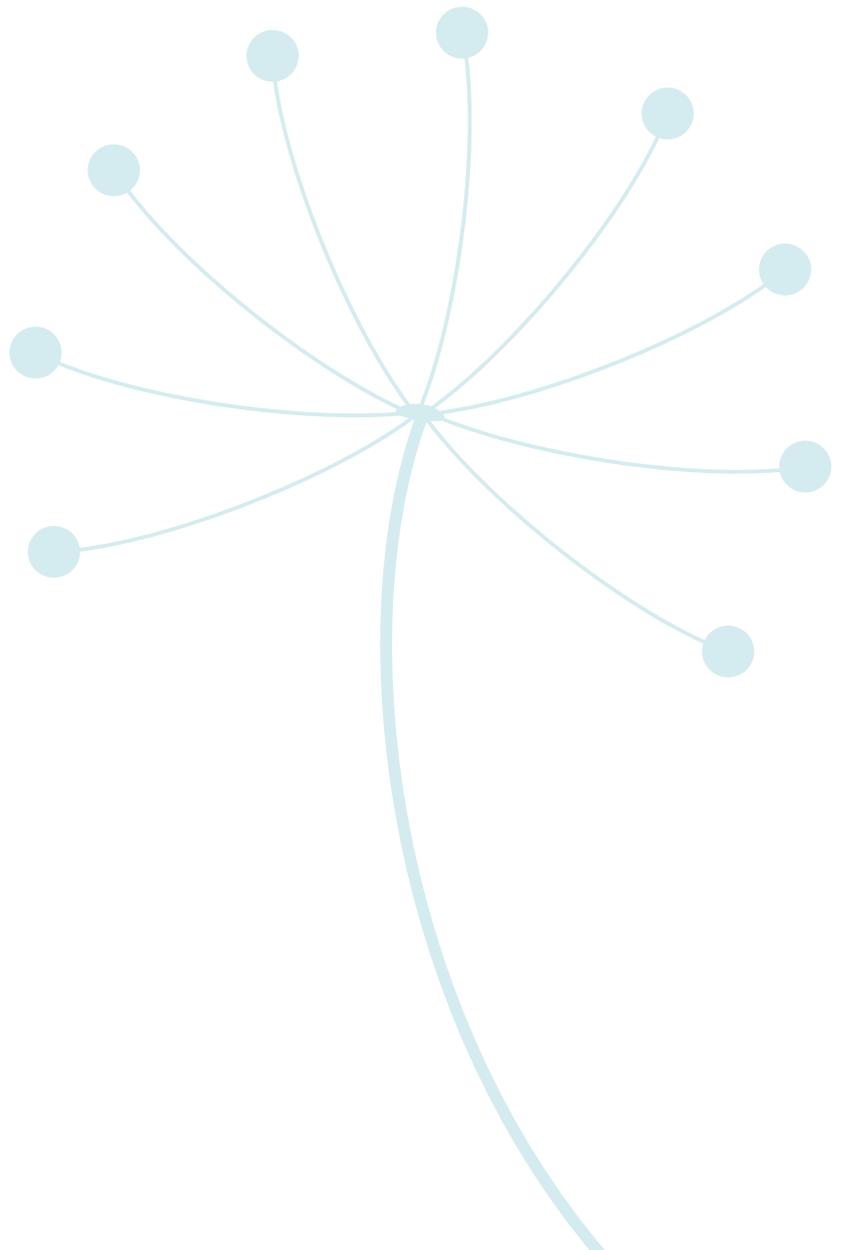
Australian Health Ministers'
Advisory Council





A national framework for recovery-oriented mental health services

POLICY AND THEORY



A national framework for recovery-oriented mental health services: Policy and theory

Print ISBN: 978-1-74186-012-2

Online ISBN: 978-1-74186-013-9

Publications approval number: 10287

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Paper-based publications

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Foreword



The release of our national recovery framework marks a pivotal moment in the history of mental health services in Australia. Recovery approaches are not new here; the movement has been gaining strength and momentum over many years.

It began as people with lived experience, carers and advocates sought greater influence and control over their experiences in mental health services. Then individual practitioners and organisations began to incorporate the recovery approach into their practice and service provision. What started as a grassroots movement led to government policy as national, state and territory governments formally adopted a recovery approach. A national recovery framework agreed by all governments across Australia is the next important step along the path.

Work on a national framework began in March 2011. Since the very beginning, people with a lived experience of mental health issues, their carers and families have participated enthusiastically in its development. Their passion and optimism have been inspirational. The process was a truly collaborative one with state and territory mental health service directorates and chief psychiatrists working in partnership to share research, gather evidence and create opportunities for participation by leaders, managers, practitioners, peer workers and volunteers in mental health services across Australia.

There was a terrific response during the consultations and submissions. The framework has benefited greatly from the wisdom and unique experience of many people with mental health issues in their own lives or in the lives of their loved ones. This is their framework. The consultations have made a lasting contribution to the national dialogue on recovery-oriented practice and this was in evidence during the National Mental Health Recovery Forum in June 2012, which was an important step in the framework's progress.

With the framework now in the public arena, the real work begins. The next stage is to make the framework live; to embed its principles into everyday practice and service delivery around the country. We need to capitalise on the momentum we have gained through the framework project and the June 2012 forum and achieve real change in how we respond to people with mental health issues and their families. We want a system that puts people with a lived experience at the heart of everything we do and offers consistently high-quality care that has long-term positive impacts on people's lives.

Change of this magnitude is not easy and it takes time. As we establish and embed recovery approaches in mental health services across Australia, this guide will be a valuable resource to help us and remind us of the important reasons why we have embarked upon this journey.

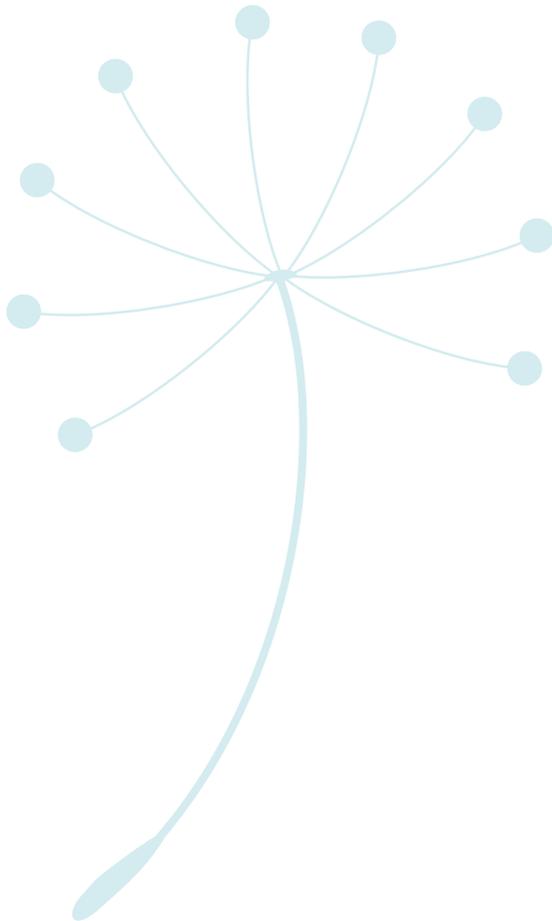
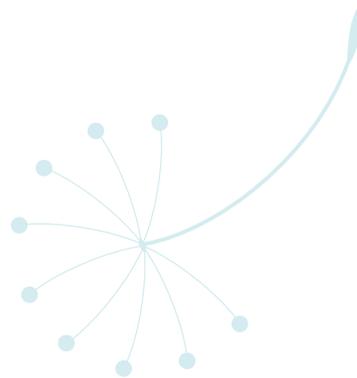
Every one of us who is involved in the provision of mental health services—leaders, practitioners, peer workers and volunteers—has a role to play. I am continually impressed by your professionalism, compassion and empathy. I know that with your commitment we will achieve our vision of recovery-focused services that meet the needs and expectations of our communities.



For now though, let's take a moment to reflect and consider what we have achieved. Above all, the framework carries a message of optimism and hope; the message that people *can* recover, and many people *do* recover, from mental illness. This is a powerful message for people who are currently living with their own mental health issues, for their carers and families, and for the practitioners and peer workers who are supporting them on their way to recovery. It is the message we all need to embrace.



Dr Peggy Brown
Chair
Australian Health Ministers' Advisory Council



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Acknowledgements



The national framework for recovery-oriented mental health services was developed under the guidance of the Mental Health, Drug and Alcohol Principal Committee.

The Committee acknowledges the significant work of the Safety and Quality Partnership Standing Committee, currently chaired by Associate Professor John Allan and formerly by Dr Ruth Vine, as well as the members of the Recovery Working Group for their tireless work and support in oversight of this framework.

The framework was informed by extensive research, submissions and consultations, as well as by a wealth of articles, reports and policy documents both national and international. Most importantly, the framework was informed by the stories, pictures, thoughts and viewpoints of people with a lived experience of mental health issues, both in their own personal experience and in the lives of those close to them.

Appreciation and thanks are extended to the many people who provided extensive feedback and comments during the development of the framework, particularly to those people with a lived experience, their carers and mental health practitioners who contributed so much of their time and expertise, participated in the public consultations and contributed their stories of lived experience. Thanks also to those who assisted in finalising the framework. Special thanks go to Dr Leanne Craze of Craze Lateral Solutions, the key author of the framework; and to Ms Carolyn Fyfe, who has shared her art as well as her stories about recovery, some of which appear in this paper.



The framework has benefited greatly from the wisdom and unique experience of many people with mental health issues in their own lives or in the lives of their loved ones.



Executive summary



About this document

This background paper is a summary of the research and policy that underpins Australia's national framework for recovery-oriented mental health services.

It provides an overview and definition of the concepts of recovery and lived experience. It outlines the policy context for a move to recovery-oriented approaches and cites relevant research. It briefly describes the practice domains and key capabilities necessary for recovery-oriented practice and service delivery. It also describes the relationship of the framework to Australia's *National Standards for Mental Health Services 2010*.

The framework is fully articulated in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers* available at www.health.gov.au/mentalhealth.

About the framework

The national framework for recovery-oriented mental health services provides a vital new policy direction to enhance and improve mental health service delivery in Australia.

It brings together a range of recovery-oriented approaches developed in Australia's states and territories and draws on national and international research to provide a national understanding and consistent approach to recovery-oriented mental health practice and service delivery. It complements existing professional standards and competency frameworks at a national and state level.

The lived experience and insights of people with mental health issues and their families are at the heart of this framework. Bringing lived experience together with the expertise, knowledge and skills of mental health practitioners offers opportunities to challenge traditional notions of professional power and expertise. The framework supports cultural and attitudinal change and encourages a fundamental review of skill mix within the mental health workforce, including increased input from those with expertise through experience.

All people employed in the mental health service system¹ regardless of role, profession, discipline, seniority or degree of contact with consumers will use the framework to guide their recovery-oriented practice and service delivery. This includes practitioners, managers, leaders, volunteers and people in administration, policy development, research, program management and service planning.

The framework defines and describes recovery and lived experience. It describes the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery-oriented principles. And it provides guidance on tailoring recovery-oriented approaches to respond to the diversity of people with mental health issues. It is underpinned by extensive research and consultation and informed by lived experience.

1 The mental health service system comprises services and programs in which the primary function is to provide promotion, prevention, early intervention, medical and psychiatric treatments and recovery support for people who experience mental health issues or mental illness, and/or their families, carers and support networks.



The framework is presented in two documents:

- *A national framework for recovery-oriented mental health services: Guide for practitioners and providers* gives guidance to mental health practitioners and services in recovery-oriented practice and service delivery.
- This companion document, *A national framework for recovery-oriented mental health services: Policy and theory*, provides background on the research and policy underpinnings of the framework.

Additional resources for practitioners, services, carers and consumers to help in the implementation of the framework are available at www.health.gov.au/mentalhealth.

It is important to recognise the significant investment that Australian mental health services have made over the last thirty years in the delivery and improvement of rehabilitation and other services that address the psychosocial needs of people experiencing mental illness. The framework benefits considerably from this investment. It was developed through an extensive consultation process involving individuals and organisations across Australia through online surveys, written submissions and consultative forums.

Policy context

A recovery orientation in mental health has largely been championed and driven by people with lived experience, their families, friends and peers as well as the non-government community mental health sector. However, mental health practitioners and policymakers have increasingly also supported their calls for cultural change. Every Australian state and territory has embedded the concept of recovery in their policy and reform platforms.

A recovery approach aligns with national policy directions in mental health services, in particular *The Roadmap for National Mental Health Reform 2012–22* and the *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009–14*. The Fourth Plan has a specific priority to promote and adopt a recovery-oriented culture in mental health services (Priority area 1). Given the rights-based focus of the recovery movement, the framework also aligns with national and international developments in human rights.

The social determinants of health

Recovery occurs within a web of relations including the individual, family and community, and is contextualised by culture, privilege or oppression, history and the social determinants of health. Recovery also occurs within the context of gender, age and developmental stages.

Most of a person's recovery occurs at home, so family, friends, communities and workplaces have an important role to play.

The significance of community connection and participation in a person's recovery highlights the importance for practitioners and services to address the social determinants of health and wellbeing. This includes the effects of discrimination and other social consequences of having a mental illness, all of which may impede recovery (Wilkinson & Marmot 2003).

Relationship to Australia's mental health service standards

Australia's *National Standards for Mental Health Services 2010* underpin the national recovery framework. Of particular importance are the 'Principles of recovery oriented mental health practice' and the 'Supporting recovery' standard (Standard 10.1).



Organisations that provide mental health or allied services can use the principles and the 'Supporting recovery' standard to assess and enhance the recovery orientation of their services. A number of other measures that assess an organisation's recovery orientation are identified in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*.

Recovery: the concept

Recovery-oriented approaches offer a transformative conceptual framework for practice, culture and service delivery in mental health service provision.

The lived experience and insights of people with mental health issues and their families are at the heart of recovery-oriented culture. The concept of recovery was conceived by, and for, people living with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of their diagnoses.

Recovery-oriented approaches recognise the value of this lived experience and bring it together with the expertise, knowledge and skills of mental health practitioners, many of whom have experienced mental illness in their own lives or in their close relationships. Recovery approaches challenge traditional notions of professional power and expertise by helping to break down the conventional demarcation between consumers and staff. Within recovery paradigms all people are respected for the experience, expertise and strengths they contribute.

Recovery-oriented approaches focus on the needs of people who use services rather than on organisational priorities.

Conceptual models of recovery processes

A number of useful models are available to help practitioners understand personal recovery processes. Andresen, Oades and Caputi (2003, 2006 & 2011) modelled recovery with four processes: finding and maintaining hope, re-establishing a positive identity, building a meaningful life and taking responsibility and control. Glover (2012) developed a model with five recovery processes: from passive to active sense of self, from hopelessness to hope, from other's control to self-control, from alienation to discovery and from disconnectedness to connectedness. Le Boutillier, Leamy, Bird, Davidson, Williams and Slade (2011) identified similar but differently worded processes to those proposed by Andresen, Oades and Caputi and by Glover.

The interconnectedness of personal and clinical recovery

There is growing agreement in the research that personal and clinical recovery are complementary and supportive of one another (Glover 2012; Slade 2009a). While recovery is much broader than symptom improvement, alleviation of distress associated with symptoms and assistance to manage the illness make an important contribution (Slade 2009a). Conversely, an increased sense of wellbeing regardless of continuing symptoms can contribute to a reduction in those symptoms or in their severity (Davidson & Tondora 2006).

Implications for practice include: the importance of collaborative working alliances with consumers, fostering personal responsibility, promoting shared decision making, supporting the development of motivation, self-management and self-empowerment and being responsive to families.



Recovery, self-determination and safety

Recognising that consumers' self-determination is a vital part of successful treatment and recovery, the principles of recovery emphasise choice and self-determination within medico-legal requirements and duty of care. Striking a balance requires an understanding of the complex and sometimes discriminatory nature of the goal of reducing all harmful risks (Slade 2009a, pp. 176–179). Maximising people's self-determination requires continued efforts to reduce coercion, seclusion and restraint.

There is a detailed discussion of recovery, self-determination and safety in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*.

Definitions

Personal recovery

There is no single definition or description of recovery. For the purposes of this framework, recovery is defined as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.

Recovery-oriented mental health practice

Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.

Recovery-oriented practice encapsulates mental health care that:

- recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues
- maximises self-determination and self-management of mental health and wellbeing
- assists families to understand the challenges and opportunities arising from their family member's experiences.



Recovery-oriented mental health service delivery

Recovery-oriented mental health service delivery is centred on and adapts to the aspirations and needs of people. It requires a shared vision and commitment at all levels of an organisation. It draws strength from, and is sustained by, a diverse workforce that is appropriately supported and resourced and includes people with lived experience of mental health issues in their own lives or in close relationships.

Recovery-oriented mental health services have a responsibility to:

- provide evidence-informed treatment, therapy, rehabilitation and psychosocial support that help people to achieve the best outcomes for their mental health, physical health and wellbeing (Victorian Department of Health 2011a)
- work in partnership with consumer organisations and a broad cross-section of services and community groups
- embrace and support the development of new models of peer-run programs and services.

Language through a recovery lens

Words and language are critically important in the mental health field where discrimination, disempowerment and loss of self-esteem can cause people to battle with self-stigma. Consistent with the language of recovery, the following 'people-first' language descriptors are used wherever possible:

- 'person', 'people with lived experience', 'lived expertise' and 'experts by experience' rather than 'clients', 'service users' or 'patients'
- 'family and support people', which includes family members, partners, friends or anyone whose primary relationship with the person concerned is a personal, supportive and caring one
- 'mental health issues', 'challenges' and 'emotional distress' are used in place of, and at times alongside, the term 'mental illness'.

Many people prefer the words 'consumers' and 'carers', and this is acknowledged in the framework.

Domains and capabilities of recovery-oriented practice and service delivery

The framework consists of 17 capabilities grouped into five fields of practice known as 'practice domains'. The domains are overlapping and should be used concurrently.

Capabilities for recovery-oriented practice and service delivery encompass underlying core principles, values, knowledge, attitudes and behaviours, skills and abilities. Individuals, teams and organisations need these capabilities in order to support people with mental health issues to live a meaningful and contributing life in their community of choice. Attaining and strengthening these capabilities is an ongoing process that takes time and commitment from leaders, professionals, staff and volunteers in mental health service provision.



A detailed description of the domains and associated capabilities can be found in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. They are summarised in Table 1 below.

Table 1: Practice domains and capabilities

Domains	Domain 1: Promoting a culture and language of hope and optimism (overarching domain) The culture and language of a recovery-oriented mental health service communicates positive expectations, promotes hope and optimism and results in a person feeling valued, important, welcome and safe.			
	Domain 2: Person 1st and holistic	Domain 3: Supporting personal recovery	Domain 4: Organisational commitment and workforce development	Domain 5: Action on social inclusion and the social determinants of health, mental health and wellbeing
Capabilities	Holistic and person-centred service	Promoting autonomy and self-determination	Recovery vision, commitment and culture	Supporting social inclusion and advocacy on social determinants
	Responsive to Aboriginal and Torres Strait Islander people	Focusing on strengths and personal responsibility	Acknowledging, valuing and learning from lived experience	Challenging stigmatising attitudes and discrimination
	Responsive to people from immigrant and refugee backgrounds	Collaborative relationships and reflective practice	Recovery-promoting service partnerships	Partnerships with communities
	Responsive to gender, age, culture, spirituality and other diversity		Workforce development and planning	
	Responsive to lesbian, gay, bisexual, transgender and intersex people			
	Responsive to families, carers and support people			

Conclusion

Helping people to find the right combination of services, treatments and supports and eliminating discrimination by removing barriers to full participation in work, education and community life is the key to the promotion and adoption of a recovery-oriented culture within mental health services.

Application of this framework will contribute to improved mental health and wellbeing as people are supported in new ways to lead fulfilling and contributing lives. The framework will foster new and innovative service designs, and in particular services designed and operated by people with lived experience of mental health issues.

All Australian jurisdictions and all mental health services have a responsibility to promote and implement the framework.



1 About this document

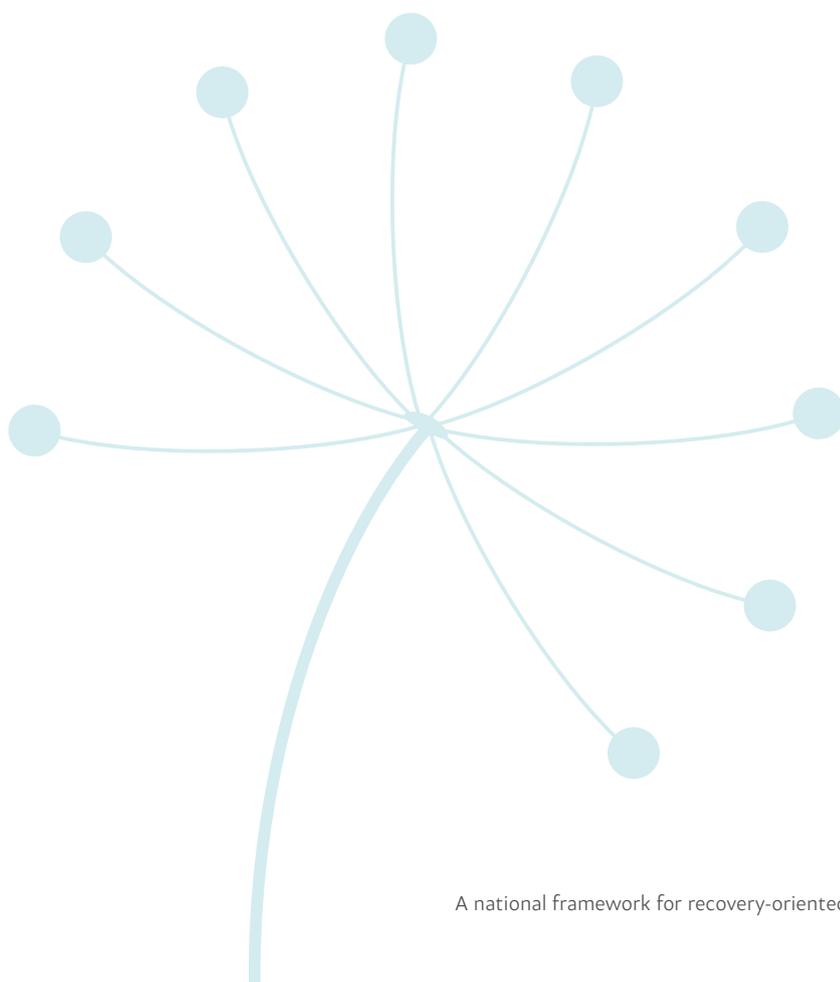
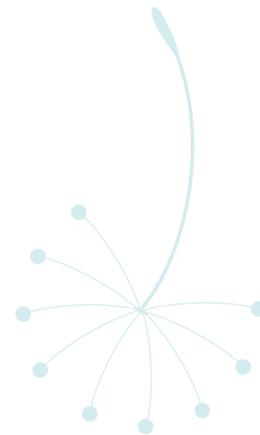


This background paper is a summary of the research and policy that underpins Australia's national recovery-oriented mental health practice framework.

It provides an overview and definition of the concepts of recovery and lived experience. It outlines the policy context for a move to recovery-oriented approaches and cites relevant research. It briefly describes the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery-oriented principles, and describes the relationship of the framework to Australia's *National standards for mental health services 2010*.

This background paper is intended for all people employed in mental health and allied service sectors, who are interested in finding out more about the policy and research that underlies this new, national recovery-oriented approach to mental health practice and service delivery.

The framework is fully articulated in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers* available at www.health.gov.au/mentalhealth.





2 About the framework

The national framework for recovery-oriented mental health services provides a vital new policy direction to enhance and improve mental health service delivery in Australia.

It brings together a range of recovery-oriented approaches developed in Australia's states and territories and draws on national and international research to provide a national understanding and approach to recovery-oriented mental health practice and service delivery.

The framework was developed through an extensive consultation process involving individuals and organisations across Australia through online surveys, written submissions and consultative forums. The framework:

- supports cultural and attitudinal change
- complements existing professional standards and competency frameworks
- encourages a fundamental review of skill mix within the workforce of mental health services, including increased input from those with expertise through experience.

The framework is for all people employed in the mental health service system² regardless of role, profession, discipline, seniority or degree of contact with people accessing services. It is also for people in administration, policy development, research, program management and service planning.

The framework is presented in two documents:

- A guide for mental health practitioners and services in recovery-oriented practice and service delivery entitled *A national framework for recovery-oriented mental health services: Guide for practitioners and providers* is the main document in the suite of resources about the framework.
- This background paper, *A national framework for recovery-oriented mental health services: Policy and theory*, provides background on the research and policy underpinnings of the framework.

Additional resources for practitioners, services, carers and consumers to help in the implementation of the framework are available at www.health.gov.au/mentalhealth.

Australian mental health services have made a significant investment over the last thirty years in the delivery and improvement of rehabilitation and other services that address the psychosocial needs of people experiencing mental illness. The framework benefits considerably from this investment.

2 The mental health service system comprises services and programs in which the primary function is to provide promotion, prevention, early intervention, medical and psychiatric treatments and recovery support for people who experience mental health issues or mental illness, their families, carers and support networks.



Lived experience—the heart of the framework

The lived experience and insights of people with mental health issues and their families are at the heart of this framework. Like all members of the community, people experiencing mental health issues desire sustaining relationships, meaningful occupation, and safety and respect in their lives. The focus on people's lived experience, and on the needs of people who use services rather than on organisational priorities, offers a new and transformative conceptual framework for practice and service delivery.

Bringing lived experience together with the expertise, knowledge and skills of mental health practitioners offers opportunities for profound cultural change in the way it challenges traditional notions of professional power and expertise. Recovery paradigms recognise that a significant proportion of the mental health service workforce has lived experience of mental health issues, either in their own lives or in close relationships. Acknowledging lived experience helps to break down the conventional demarcation between consumers and staff. All people are respected for the experience, expertise and strengths they contribute.

Purpose of the framework

The framework will help mental health professionals in a range of settings—hospitals, community mental health services and other public, private and non-government health and human service settings—to align their practice with recovery principles.

The framework will encourage a fundamental review of skill mix within the mental health workforce. As services heighten their value of lived experience, the balance in the workforce between experts by training and experts by experience will continue to shift, and there will be an expanded role for peer practitioners—people in recovery, their families and their carers.

The framework will influence the design and development of innovative service models and systems of care such as trauma-informed approaches and services designed and operated by people with a lived experience.

The ultimate goal of the framework is to improve outcomes and quality of life for people experiencing mental health issues.





3 Policy context

A recovery orientation in mental health has largely been championed and driven by people with lived experience, their families, friends and peers as well as the non-government community mental health sector. However, mental health practitioners and policy makers have increasingly supported their calls for cultural change.

Every Australian state and territory has embedded the concept of recovery in their policy and reform platforms, and many mental health professionals promote person-led recovery and have incorporated a recovery-oriented approach into their practice. A national recovery framework will support consistent and high-quality recovery-oriented service delivery and practice nationally.

The *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009–14* recognises the role that mental health services and practitioners play in creating environments supportive of recovery. The Australian Health Ministers' Advisory Council, a body comprising all Australian health ministers, endorsed the plan and each of its actions. Priority area 1 of the plan is 'Social inclusion and recovery', and one action in this priority area is to 'adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models'.

The Safety and Quality Partnership Standing Committee of the Mental Health, Drug and Alcohol Principal Committee is responsible for progressing the plan's action on recovery, and is providing oversight to the development and implementation of this national recovery framework.

Australia's *National Standards for Mental Health Services 2010* apply to all state and Commonwealth funded mental health services. They were developed to foster continuous quality improvement and to provide clear direction to embed recovery principles into service delivery, culture and practice. This national recovery framework will provide guidance to mental health services in their implementation of Standard 10.1, known as the 'Recovery standard'. More detail about the relationship between the national recovery framework and the standards is provided in the section entitled 'Relationship to Australia's mental health service standards'.

The revised *National practice standards for the mental health workforce* (2013) were informed by this national recovery framework and other national and international work on mental health practice. The practice standards include elements consistent with recovery-oriented care.

The *Mental health statement of rights and responsibilities*, revised in 2012, is a key policy of the *National mental health strategy*. The statement highlights the vital importance of the opportunity to achieve recovery. It clearly sets out the rights and responsibilities of individuals who seek assessment, support, care, treatment, rehabilitation and recovery.



The Roadmap for National Mental Health Reform 2012–22, launched in December 2012 as an initiative of the Council of Australian Governments, articulates the vision for the future of mental health care in Australia:

... a society that values and promotes the importance of good mental health and wellbeing, maximises opportunities to prevent and reduce the impact of mental health issues and mental illness and supports people with mental health issues and mental illness, their families and carers to live full and rewarding lives (COAG 2012).

The ongoing reform set out in the roadmap includes recovery-oriented care elements.

Australia's policy and service reforms, like those of other nations, are occurring against a backdrop of significant developments in international human rights. Of relevance to this framework are the following international agreements:

- *The United Nations universal declaration of human rights (1948)*
- *The United Nations Convention on the rights of persons with disability (2006)*
- *The United Nations Principles for the protection of persons with mental illness and for the improvement of mental health care (1991).*

In recent years, Australian jurisdictions have been reviewing and changing their mental health legislation in an attempt to attain a greater focus on human rights and to provide for external and independent review.

Recovery and the social determinants of health

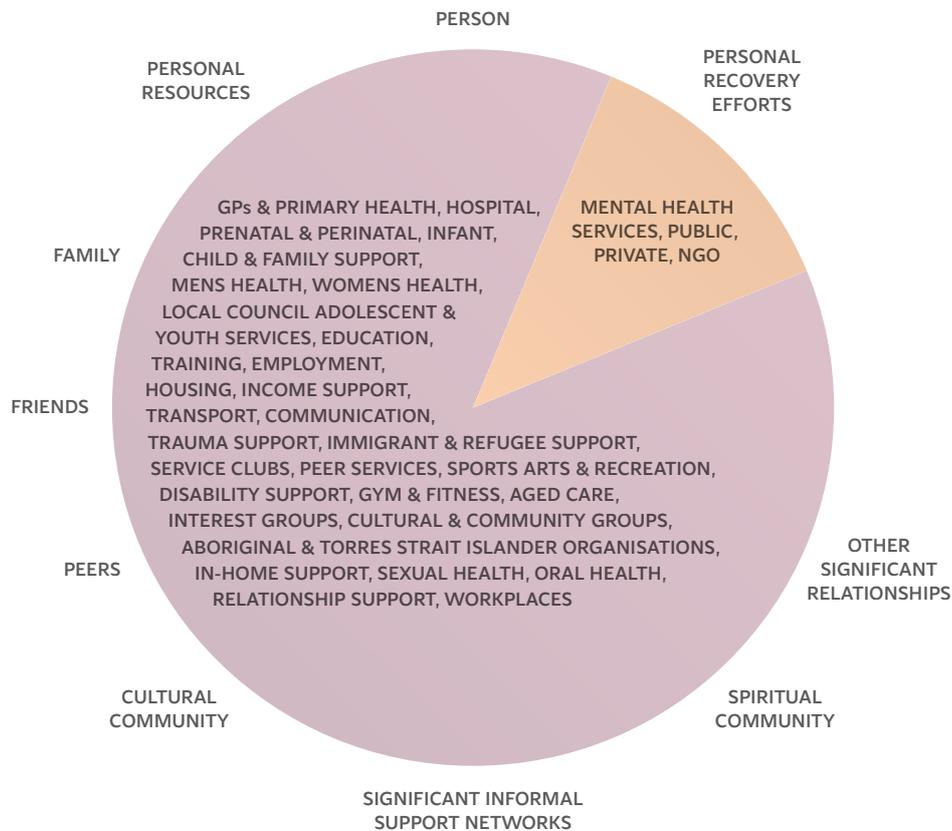
Biological, psychological, physical, environmental, economic, social and political factors all impact on health and wellbeing at a personal, local and global level. The mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and wellbeing measures.

Recovery occurs within a web of relations, including the individual, family and community, and is contextualised by culture, privilege or oppression, history and the social determinants of health. Recovery also occurs within the context of gender, age and developmental stages.

Many practitioners, services and organisations outside the mental health service system will contribute to an individual's recovery process. Government, private and non-government agencies from other service sectors have an impact on how people with mental illness can maximise their quality of life. Figure 1 shows some of these agencies, including providers of employment support, education, training and housing.



Figure 1: Groups involved in a person's recovery



Most of a person's recovery occurs at home, so their family, friends, neighbours, local community, church, clubs, school or workplace have an important role to play. Recovery-oriented services can facilitate and nurture these connections so people gain the maximum benefit from these supports.

Recovery is a concept everyone can relate to, because everyone experiences growth, satisfaction and happiness as well as change, uncertainty, loss and grief. Many people in the community are living with or recovering from illness, disabilities, injuries or trauma. Others are struggling with financial stress and other socioeconomic hardship, dislocation, voluntary or forced migration, disasters and local area decline or rapid development. In this sense recovery is everyone's business and requires a whole-of-community approach.

The significance of community connection and participation in a person's recovery highlights the importance for practitioners and services to address the social determinants of health and wellbeing. This includes the effects of discrimination and other social consequences of having a mental illness, all of which may impede recovery (Wilkinson & Marmot 2003).



4 Relationship to Australia's mental health service standards



Australia's *National Standards for Mental Health Services 2010* underpin the national recovery framework. Of particular importance are the 'Principles of recovery oriented mental health practice' and the 'Supporting recovery' standard (Standard 10.1). They are reproduced here in full.

Organisations that provide mental health or allied services can use the principles and the 'Supporting recovery' standard to assess the recovery orientation of their services. A number of other measures that assess an organisation's recovery orientation are identified in *A national framework for recovery oriented mental health services: Guide for practitioners and providers*.

Principles of recovery oriented mental health practice

1. Uniqueness of the individual

Recovery oriented mental health practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
- accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive.

2. Real choices

Recovery oriented mental health practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.



3. Attitudes and rights

Recovery oriented mental health practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to each individual
- promotes and protects individuals' legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual
- instils hope in an individual's future and ability to live a meaningful life.

4. Dignity and respect

Recovery oriented mental health practice:

- consists of being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, particularly for their values, beliefs and culture
- challenges discrimination and stigma wherever it exists within our own services or the broader community.

5. Partnership and communication

Recovery oriented mental health practice:

- acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement
- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

6. Evaluating recovery

Recovery oriented mental health practice:

- ensures and enables continual evaluation of recovery-based practice at several levels
- individuals and their carers can track their own progress
- uses the individual's experiences of care to inform quality improvement activities
- the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and wellbeing measures.



The 'Supporting recovery' standard (Standard 10.1)

The MHS incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

Criteria

- 10.1.1 The MHS actively supports and promotes recovery oriented values and principles in its policies and practices
- 10.1.2 The MHS treats consumers and carers with respect and dignity
- 10.1.3 The MHS recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities
- 10.1.4 The MHS encourages and supports the self-determination and autonomy of consumers and carers
- 10.1.5 The MHS promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination
- 10.1.6 The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives
- 10.1.7 The MHS supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community
- 10.1.8 The MHS demonstrates systems and processes for consumer and carer participation in the development, delivery and evaluation of the services
- 10.1.9 The MHS has a comprehensive knowledge of community services and resources and collaborates with consumers and carers to assist them to identify and access relevant services
- 10.1.10 The MHS provides access for consumers and their carer(s) to a range of carer-inclusive approaches to service delivery and support.

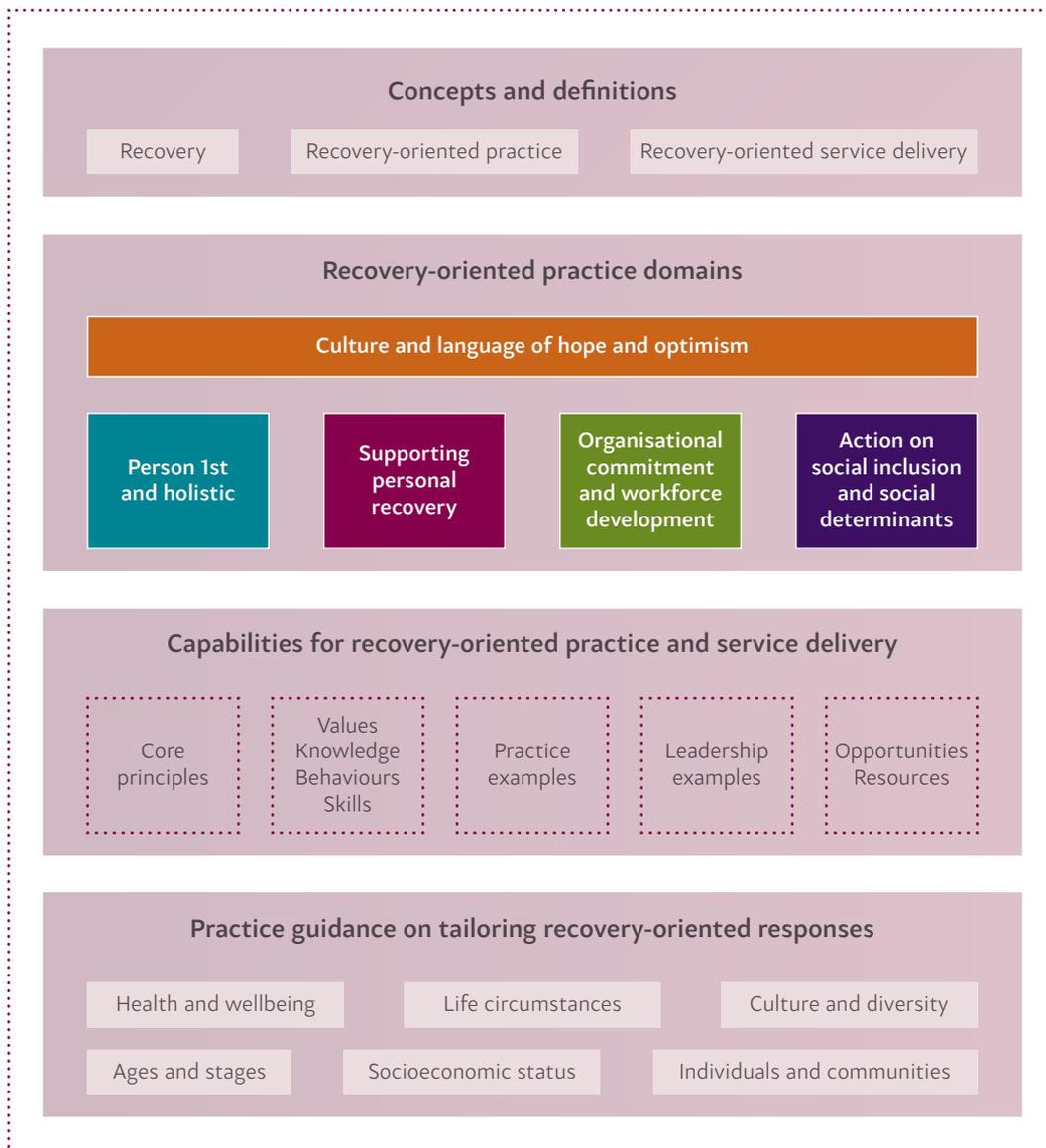


5 The national recovery framework at a glance



Australia's national recovery-oriented mental health practice framework provides concepts and definitions of recovery, describes the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery-oriented principles and provides guidance on tailoring recovery-oriented approaches to respond to the diversity of people with mental health issues, to people in different life circumstances and at different ages and stages of life.

Figure 2: The national framework for recovery-oriented mental health services: at a glance



6 Recovery: the concept



The concept of recovery was conceived by, and for, people with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of diagnoses.

The recovery movement began in the 1970s primarily as a civil rights movement aimed at restoring the human rights and full community inclusion of people with mental health issues.

Recovery approaches are viewed by the consumer movement as an alternative to the medical model with its emphasis on pathology, deficits and dependency. There is no single description or definition of recovery, because recovery is different for everyone. However, central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination.

Some characteristics of recovery commonly cited are that it is:

- a unique and personal journey
- a normal human process
- an ongoing experience and not the same as an end point or cure
- a journey rarely taken alone
- nonlinear—frequently interspersed with achievements and setbacks.

Recovery is a struggle for many people. The struggle might stem from severity of symptoms, side effects of medication, current or past trauma and pain, difficult socioeconomic circumstances, or the experience of using mental health services. Practitioners can also struggle as a result of the constraints of their work environment or when they sense a person's despair (Davidson & Roe 2007).

Personal recovery is defined within this framework as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.

Recovery approaches are different depending upon where a person is on their recovery journey. During an acute phase of illness, the person's capacity may be impaired to the extent that alleviation of distress and the burden of symptoms, as well as safety, is the primary focus of treatment and care. Regaining capacity for self-determination or deeper engagement should be a focus in the next stage of treatment and support. At later stages, when capacity is improved, there are opportunities for the person to consider broader recovery strategies.

The concept of recovery is represented in Figure 3 on the following page.



Figure 3: The concept of recovery



Recovery as an everyday human experience

Glover (2012) views people in recovery as 'living, loving, working and playing in their community' or in other words, doing the things that people need or wish to do or enjoy doing every day. The Mental Health Coordinating Council explains a benefit of this understanding of recovery:

Viewing recovery as a normal human process 'demystifies' the process of recovery from mental health problems and puts people in a better position to support someone in their recovery journey (MHCC 2008, p.14).

Recovery and relationships

Recovery is a personal journey, but it is rarely undertaken alone. For this reason, many commentators with lived experience of mental illness emphasise the theme of relationships with family, friends, peers and practitioners.

[It was] important for people in recovery to feel as if they are supported and cared for and identify 'being there' and available as a factor within friendships that seemed to help people in recovery. For professionals or caregivers, to go the extra step, to take a risk, to reach out and make a connection and 'be there' was important (Brown & Kandirikirira 2007, pp. 75–79).

Boydell et al. (2002) take up the theme of the importance of peers and refer to an enhanced level of understanding, support and acceptance that peers bring to one another by sharing their personal experiences of living with and overcoming mental health issues. This mutuality emphasises the role of peers in alleviating alienation and loneliness.

People with lived experience also discuss the importance to recovery of their parenting roles. A person detained in a forensic facility explained:

I remember my children coming to visit me in the hospital and at the time I was considered a danger to my children and myself. My children wanted to go outside on the grass to play, and luckily there was enough staff on duty for me to go out with them. Then my daughter fell down a manhole in the hospital grounds and she needed stitches in her leg. The hospital was very quick and helpful at arranging for me to be accompanied to the A&E with my daughter. She wanted her mum with her at a time of great distress and this was allowed to happen. This helped me in my self-esteem around being a parent and was very important in aiding my recovery and bond to my children (E.H. in Roberts et al. 2008, p. 178).

Fyfe explains:

I never really had a name for this piece of art. I painted it to help educate others on the impacts of invasion, colonisation, segregation to assimilation and how this journey has affected the wellbeing of our Indigenous race socially, emotionally, culturally and spiritually—mind, body and soul.

Recovery and diversity

People's experience of recovery will be influenced by:

- their cultural identity—how they see self, kinship and relations with the broader community
- their explanatory models of illness, distress and wellness
- their experiences of torture, trauma, displacement, loss, racism and discrimination
- their spirituality.

The research tells of the serious and compounding emotional problems experienced by people with mental health issues emerging from discrimination on account of ethnicity, race, culture or sexual orientation. For some, the concealment of important aspects of oneself reflects a desperate attempt to survive, the need to 'pass' in an attempt to fit in. Gene Deegan describes how he tried to hide his mental health issues.

I'd internalized the old stereotypes about mental illness ... I feared losing my identity, hopes and dreams. I hid them at all costs. Deep down I stigmatized myself (Deegan, G 2003, p. 369).

Accounts tell of how hiding personal identity places a heavy burden on an individual and can impede recovery.

Recovery as living well

Commentators and researchers with lived experience also emphasise living well irrespective of any limitations arising from mental illness.

... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by 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 1993).

Glover (2012) describes recovery as self-righting – a natural process that people undertake, usually unconsciously, in response to difficulties and distress that interrupt the status quo of daily life.

Self-defined and not the same as cure

Pat Deegan, a psychologist who is in recovery with schizophrenia, reflects on the ongoing nature of her recovery.

Recovery is not the same thing as being cured. Recovery is a process not an end point or a destination. Recovery is an attitude, a way of approaching the day and facing the challenges. Being in recovery means recognising limitations in order to see the limitless possibilities. Recovery means being in control. Recovery is the urge, the wrestle, and the resurrection ...



My journey of recovery is still ongoing. I still struggle with symptoms, grieve the losses I have sustained ... I am also involved in self-help and mutual support and still use professional services including medications, psychotherapy, and hospitals. However, I do not just take medications or go to the hospital. I have learned to use medications and to use the hospital. This is the active stance that is the hallmark of the recovery process (Deegan, P 1996, p. 91).

A nonlinear process

Pat Deegan also discusses the nonlinear nature of recovery and how recovery is frequently interspersed with both achievement and setbacks.

Recovery is not a linear process marked by successive accomplishments. The recovery process is more accurately described as a series of small beginnings and very small steps.

Professionals cannot manufacture the spirit of recovery and give it to consumers. Recovery cannot be forced or willed. However, environments can be created in which the recovery process can be nurtured like a tender and precious seedling. To recover, psychiatrically disabled persons must be willing to try and fail, and try again (Deegan, P 1988, p. 11).

This brief discussion of the different perspectives of writers and researchers with lived experience of mental health issues reflects the importance of understanding and acknowledging that recovery will mean different things for different people.

Conceptual models of recovery processes

In recent years, mental health services and programs throughout Australia have adopted different models for helping staff to understand personal recovery processes and how they might enable and support personal recovery. While this new national framework is not seeking to standardise the use of particular models, the following models are highlighted as useful examples.

Andresen, Oades and Caputi (2003, 2006 and 2011)

By studying personal accounts of recovery, this Australian team of researchers developed a conceptual model of recovery processes to guide research and training and to inform clinical practices. The team identified four processes involved with personal recovery.

- **Finding and maintaining hope**—believing in oneself; having a sense of personal agency; optimistic about the future
- **Re-establishing a positive identity**—incorporates mental health issues or mental illness but retains a positive sense of self
- **Building a meaningful life**—making sense of illness or emotional distress; finding a meaning in life beyond illness; engaged in life
- **Taking responsibility and control**—feeling in control of illness and distress and in control of life.

Glover (2012)

Glover's model reflects the efforts that people undertake in their personal recovery journeys through a set of five processes.



- **From passive to active sense of self**—moving from the passive space of being a recipient of services to reclaiming one’s strengths, attributes and abilities to restore recovery
- **From hopelessness and despair to hope**—moving from a space of hopelessness and despair to one of hope
- **From others’ control to personal control and responsibility**—moving from others taking responsibility for recovery to the person taking, holding and retaining responsibility
- **From alienation to discovery**—‘finding meaning and purpose in the journey, doing more of what works and less of what does not work; learning from past experiences and incorporating that lesson into the present; acknowledging that journeys always have something to teach us and contribute to our sense of discovery’
- **From disconnectedness to connectedness**—moving from an identity of illness or disability to an appreciation of personal roles and responsibilities and to ‘participating in life as a full citizen and not through the powerlessness of illness’.

As with the model developed by Andresen, Oades and Caputi, this personal recovery effort model emphasises personal responsibility and personal control.

This is a challenging concept for workers in helping and caring professions. Their impulse is to ‘do for another’ who is experiencing distress, pain, illness or disability. However, constantly ‘doing for another’ can contribute to a state of impotence and inability. A recovery approach encourages people to take an active role and reclaim responsibility for the direction of their life (Glover 2012).

Le Boutillier, Leamy, Bird, Davidson, Williams and Slade (2011)

This study analysed 30 international documents to identify the key characteristics of recovery-oriented practice guidance. The researchers developed an overarching conceptual framework to aid the translation of recovery guidance into practice. The five practice domains and 17 competencies of recovery-oriented practice developed for Australia’s national framework are consistent with the themes and categories of recovery identified by these researchers.

In terms of people’s recovery processes, this research team identified similar but differently worded processes to those proposed by Andresen, Oades and Caputi and by Glover.

The interconnectedness of personal recovery and clinical recovery

A growing number of commentators (including researchers with personal experience of mental illness), while acknowledging the difference between clinical recovery and personal recovery, argue that the two types of recovery are complementary and support one another (Glover 2012; Slade 2009a).

A recent study conducted by researchers with lived experience explored the views of people with psychosis about the relationship between clinical recovery and personal recovery. The research team reports:

All participants highlighted symptom change as an indicator of their recovery, and change in symptoms was often accompanied by alleviation of distress and personal change.

Improvements in psychotic symptoms may be important to recovery, but only in conjunction with a range of other factors. Furthermore, the findings in relation to the need for change within symptoms may indicate that although full symptom alleviation or removal may be important for some service users, for others, changes in the nature of the symptoms may be just as important. For example, recovery may mean the continued presence of symptoms but without their negative impact (Wood et al. 2010, pp. 468–469).



There is general agreement in the research that while recovery is much broader than symptom improvement, alleviation of distress associated with symptoms and assistance to manage the illness make an important contribution (Slade 2009a). There is also agreement that an increased sense of wellbeing regardless of continuing symptoms can contribute to a reduction in those symptoms or in their severity (Davidson et al. 2006). Increasingly the importance of physical health, activity, fitness, exercise, healthy diets and healthy lifestyles are being emphasised. Physical fitness through increased activity and exercise contribute to recovery by increasing stress tolerance, promoting resiliency and strengthening a person's sense of wellbeing and self-mastery.

The major implication for practice and service delivery arising from the complementary nature of clinical recovery and personal recovery is the need for practitioners and services to offer their assistance and expertise through the medium of a collaborative working alliance with each person and where appropriate, their family (Oades et al. 2005). Another principle is the mutual sharing of lived and trained expertise in crafting a service plan.

Key practice tasks emerging from the interconnectedness of clinical and personal recovery include: fostering personal responsibility, promoting shared decision making, supporting the development of motivation, self-management and self-empowerment, and being responsive to families.

Recovery, self-determination and safety

Recognising that consumers' self-determination is a vital part of successful treatment and recovery, the principles of recovery emphasise choice and self-determination within medico-legal requirements and duty of care. Striking a balance requires an understanding of the complex and sometimes discriminatory nature of the goal of reducing all harmful risks (Slade 2009a, pp. 176–179). Services must manage various tensions including:

- maximising choice
- supporting positive risk-taking
- the dignity of risk
- medico-legal requirements
- duty of care
- promoting safety.

Maximising people's self-determination requires continued efforts to reduce coercion, seclusion and restraint.

Australia's National Mental Health Seclusion and Restraint Project (NMHSRP) 2007–09 promoted discussion and action to reduce seclusion and restraint. The 11 Beacon demonstration sites established as part of the project demonstrated that simple changes can lead to major improvements. The following strategies were identified as influencing positive outcomes to reduce seclusion: leadership to effect organisational change, the use of data to inform practice, investment in workforce development and debriefing techniques involving people with a lived experience, their carers and staff.

Australian state and territory governments as well as professional associations embraced the objectives of the NMHSRP and reviewed their policies and practices.

There is a detailed discussion of recovery, self-determination and safety in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*.



7 Definitions



Defining personal recovery

There is no single definition or description of recovery. Starting with the initial assumption that personal recovery is different for everyone, it is defined within this framework as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.

Defining a recovery-oriented approach

All people aspire to live, love, work and enjoy themselves in a community of their own choosing and to create a happy and meaningful life for themselves. It is no different for people with lived experience of mental health issues. A recovery-oriented approach supports people with mental health issues to live well and to live the life they choose (New Zealand Mental Health Commission 2001; Shepherd, Boardman & Slade 2008). A recovery-oriented approach is not linked with any particular model, nor is it confined to any particular service setting or phase of care (Victorian Department of Health 2011a). Defining characteristics of a recovery-oriented mental health service include:

- developing and drawing on their own expertise and resources as well as the experiences and resources of people with lived experience of mental health issues
- supporting people as they take responsibility for and reclaim an active role in their life, mental health and wellbeing
- supporting people to embrace their strengths, resilience and inherent capacities for living a full and meaningful life of their choosing
- supporting local communities to accept, welcome and include people with mental health issues
- embracing and enabling people with mental health issues, their families and their communities to interact and draw benefit from one another (New Zealand Mental Health Commission 2001)
- recognising the possibility that anyone accessing the service may have a limited experience of unresolved trauma underlying their mental distress and that recovery evolves from the lived experience of trauma as well.

Defining recovery-oriented mental health practice

Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.

Capabilities for recovery-oriented practice and service delivery encompass underlying core principles, values, knowledge, attitudes and behaviours, skills and abilities. Individuals, teams and organisations need these capabilities in order to support people with mental health issues to live a meaningful and contributing life in their community of choice.



Recovery-oriented practice promotes an active and collaborative relationship between people accessing mental health services and mental health practitioners, whereby:

... people with lived experience are considered experts on their lives and experiences while mental health professionals are considered experts on available treatment services (Victorian Department of Health 2011, p.2).

For the purposes of this framework, recovery-oriented practice is understood as encapsulating mental health care that:

- recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people who experience mental health issues
- maximises self-determination and self-management of mental health and wellbeing and involves person-first, person-centred, strengths-based and evidence-informed treatment, rehabilitation and support acknowledges the diversity of peoples' values and is responsive to people's gender, age and developmental stage, culture and families as well as people's unique strengths, circumstances, needs, preferences and beliefs
- involves a holistic approach that addresses a range of factors, including social determinants, that impact on the wellbeing and social inclusion of people experiencing mental health issues and their families, including housing, education, employment, income, isolation and geographic distance, relationships, social connectedness, personal safety, trauma, stigma, discrimination and socioeconomic hardship
- helps families or support people to understand their family member's experiences, recovery processes and how they can assist in their recovery while also helping them with their own needs for counselling, therapy, education, training, guidance, support services, peer support and advocacy (Victorian Department of Health 2011a; Slade 2009a; New Zealand Mental Health Commission 2011; Queensland Health 2005).
- understands that people who have lived experience of unresolved trauma struggle to feel safe, considers the possibility of unresolved trauma in all service settings, and incorporates the core principles of trauma-informed care into service provision.

Defining recovery-oriented mental health service delivery

Recovery-oriented service delivery is centered on and adapts to people's aspirations and needs, rather than people having to adapt to the requirements and priorities of services. Recovery-oriented service delivery is welcoming of, and affords respect and safety to all people.

Recovery-oriented mental health services have a responsibility to provide evidence-informed treatment, therapy, rehabilitation and psychosocial support that assist in achieving the best outcomes for people's mental health, physical health and wellbeing (Victorian Department of Health 2011a).

Recovery-oriented service delivery is a vision and commitment shared at all levels of an organisation. It draws strength and is sustained by a diverse workforce that is appropriately supported and resourced, and includes people with lived experience of mental health issues and their family and support group.

Recovery-oriented mental health service delivery embraces and supports the development of new models of peer-run programs and services.



In the Australian context, recovery-oriented mental health services have a particular responsibility to be responsive to Aboriginal and Torres Strait Islander cultures, values, belief systems and perspectives of identity, family, mental health, physical health and wellbeing.

It is also incumbent on services to recognise and respond to the trauma experienced by Stolen Generations and Forgotten Australians. It is understood that many survivors and their families and communities continue to struggle with the health impacts arising from the trauma of forcible removal.

In advocating for the social inclusion and human rights of people with mental health issues and in seeking to reduce stigma and discrimination, recovery-oriented services work in partnership with consumer organisations and a broad cross-section of services and community groups.

Defining mental health services

The mental health service system comprises services and programs in which the primary or a key function is to provide promotion, prevention and early intervention, medical and psychiatric treatments, support for physical health and fitness, psychological therapies including psychotherapy and counselling, rehabilitation, psychosocial and recovery support, peer-support, community development and other support for people who experience mental health issues and their families, carers and support networks. Mental health services might also be provided by organisations that offer a broader range of health and human services.

Defining mental health practitioner

Mental health practitioners provide treatment, rehabilitation or support to people with a mental illness or psychiatric disability (adapted from *National Standards for Mental Health Services 2010*). They include psychiatrists, psychologists, mental health nurses, mental health counsellors, social workers, occupational therapists, consumer/family consultants, peer practitioners, psychosocial and recovery support workers, Aboriginal and Torres Strait Islander health workers, social-emotional wellbeing workers, service managers and team leaders.

Other professionals who contribute to the wellbeing of people with mental health issues include pharmacists, nutritionists and dieticians, sports exercise practitioners, physiotherapists, health promotion educators and other allied health and community practitioners.



8 Language through a recovery lens



Words and language are critically important in the mental health field where discrimination, disempowerment and loss of self-esteem can cause people to battle with self-stigma.

Language powerfully shapes sense of self by influencing how people describe themselves and are described by others (Slade 2009b). Language also shapes possibilities, and promotes positivity and strengths more generally. It helps people to break with the past, transform the present and usher in the future they wish to see. In changing language, people are able to 'be the change [they] wish to see' (Mahatma Gandhi).

Recovery paradigms increasingly advocate the adoption of such 'people-first' language descriptors as: 'person in recovery', 'person who is expert by training' or 'person with lived experience' rather than descriptions that focus on deficits or relationships to services (Recovery Devon 2012).

The national framework adopts a similar approach. Consistent with the language of recovery, the terms 'person', 'people with lived experience', 'lived expertise' and 'experts by experience' are used wherever possible rather than 'clients', 'service users' or 'patients'. Family and support include family members, partners, friends or anyone whose primary relationship with the person concerned is a personal, supportive and caring one. The terms 'lived experience' and 'experts by experience' may also apply to family members, partners and friends.

Many people find a depth of personal meaning in the terms 'consumers' and 'carers'. These terms are acknowledged and used throughout the framework.

To further reflect language consistent with recovery paradigms, the terms 'mental health issues', 'challenges' and 'emotional distress' are used in place of, and at times alongside, the term 'mental illness'.



9 Domains and capabilities of recovery-oriented practice and service delivery



The framework consists of 17 capabilities grouped into five fields of practice known as 'practice domains'. The domains are overlapping and should be used concurrently.

The domains are consistent with those identified in Victoria's *Framework for recovery-oriented practice* (2011) as well with the practice development pathways identified in the Queensland Health and Community Services Workforce Council's *Values into action: community mental health practice framework* (2012). The domains and their capabilities are also consistent with the evidence-based schema of Le Boutillier et al. (2011).

Capabilities for recovery-oriented practice and service delivery encompass underlying core principles, values, knowledge, attitudes and behaviours, skills and abilities. Individuals, teams and organisations need these capabilities in order to support people with mental health issues to live a meaningful and contributing life in their community of choice. Attaining and strengthening these capabilities is an ongoing process that takes time and commitment from leaders, professionals, staff and volunteers in mental health service provision.

A detailed description of the domains and associated capabilities can be found in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*.

Domain 1: Promoting a culture and language of hope and optimism is the overarching domain and is integral to the other domains.

Domain 1: Promoting a culture and language of hope and optimism

A service culture and language that makes a person feel valued, important, welcome and safe, communicates positive expectations and promotes hope and optimism—this is central to recovery-oriented practice and service delivery.

Capability 1A The culture and language of a recovery-oriented mental health service communicates positive expectations, promotes hope and optimism and results in a person feeling valued, important, welcome and safe.

Domain 2: Person 1st and holistic

Putting people who experience mental health issues first and at the centre of practice and service delivery; viewing a person's life situation holistically.

Capability 2A Holistic and person-centred treatment, care, rehabilitation and psychosocial and other recovery support

Capability 2B Responsive to Aboriginal and Torres Strait Islander people, families and communities

Capability 2C Responsive to people from immigrant and refugee backgrounds, their families and communities



- Capability 2D** Responsive to and inclusive of gender, age, culture, spirituality and other diversity irrespective of location and setting
- Capability 2E** Responsive to lesbian, gay, bisexual, transgender and intersex people, their families of choice, and communities
- Capability 2F** Responsive to families, carers and support people

Domain 3: Supporting personal recovery

Personally defined and led recovery at the heart of practice rather than an additional task.

- Capability 3A** Promoting autonomy and self-determination
- Capability 3B** Focusing on strengths and personal responsibility
- Capability 3C** Collaborative relationships and reflective practice

Domain 4: Organisational commitment and workforce development

Service and work environments and an organisational culture that are conducive to recovery and to building a workforce that is appropriately skilled, equipped, supported and resourced for recovery-oriented practice.

- Capability 4A** Recovery vision, commitment and culture
- Capability 4B** Acknowledging, valuing and learning from people's lived experience and from families, staff and communities
- Capability 4C** Recovery-promoting service partnerships
- Capability 4D** Workforce development and planning

Domain 5: Action on social inclusion and the social determinants of health, mental health and wellbeing

Upholding the human rights of people experiencing mental health issues and challenging stigma and discrimination; advocating to address the poor and unequal living circumstances that adversely impact on recovery.

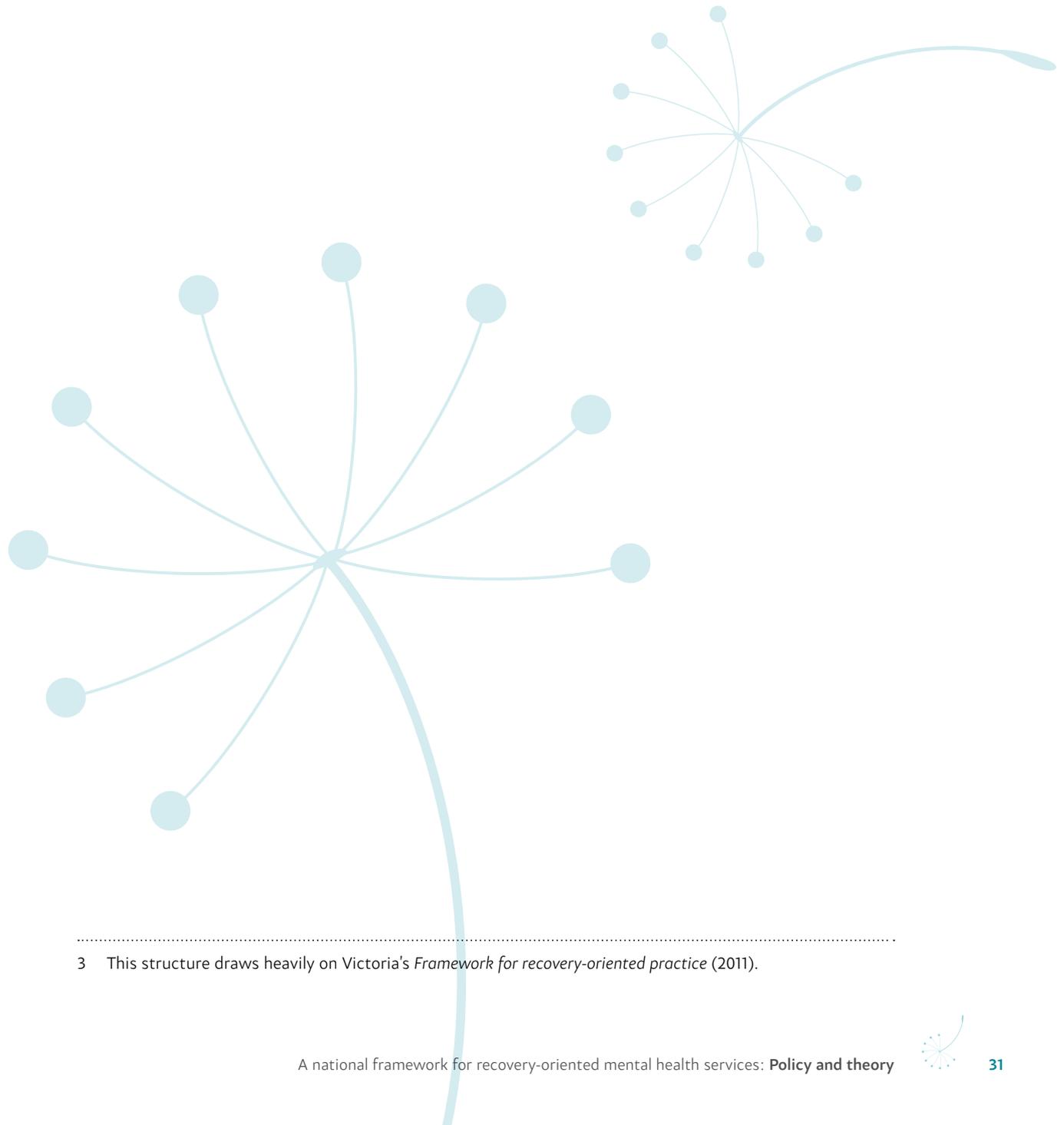
- Capability 5A** Supporting social inclusion and advocacy on social determinants
- Capability 5B** Actively challenging stigmatising attitudes and discrimination, and promoting positive understandings
- Capability 5C** Partnerships with communities.

The capabilities are described in detail in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*.



Each key capability is described using the following defining characteristics:³

- **Core principles** that should govern all practice, decisions and interactions in the provision of mental health care within the relevant domain
- **Values, knowledge, behaviours and skills** consistent with recovery-oriented practice required to enact the core principles
- **Recovery-oriented practice examples** intended to support individual practitioners to translate principles of recovery into their daily practice.
- **Recovery-oriented leadership examples** directed at service leaders and managers that describe activities and governance structures that could be expected of a recovery-oriented organisation
- **Opportunities** during implementation
- **Resources** to guide and support implementation.



3 This structure draws heavily on Victoria's *Framework for recovery-oriented practice* (2011).





10 Conclusion

Helping people to find the right combination of services, treatments and supports and eliminating discrimination by removing barriers to full participation in work, education and community life is the key to the promotion and adoption of a recovery-oriented culture within mental health services.

Application of this framework will contribute to improved mental health and wellbeing as people are supported in new ways to lead fulfilling and contributing lives. The framework will foster new and innovative service designs, and in particular, services designed and operated by people with lived experience of mental health issues.

All Australian jurisdictions and all mental health services have a responsibility to promote and implement the framework.



Glossary

Advance directive

See Psychiatric advance directive.

Capabilities

Capabilities for recovery-oriented practice and service delivery encompass underlying core principles, values, knowledge, attitudes and behaviours, skills and abilities. Individuals, teams and organisations need these capabilities in order to support people with mental health issues to live a meaningful and contributing life in their community of choice.

Carer

A person of any age who provides personal care, support and assistance to another person because the other person has a disability, a medical condition, a mental illness or is frail (*Mental health statement of rights and responsibilities 2012*).

Clinical recovery

Primarily defined by mental health professionals and pertains to a reduction or cessation of symptoms and 'restoring social functioning' (Victorian Department of Health 2011). See also Personal recovery.

Coercion

Comprises seclusion and restraint—see definitions.

Diversity

A broad concept that includes age, personal and corporate background, education, function and personality. Includes lifestyle, sexual orientation, ethnicity and status within the general community (*National Standards for Mental Health Services 2010*).

Forgotten Australians

The estimated 500,000 Indigenous children, non-Indigenous children and child migrants who experienced care in institutions or outside a home setting in Australia during the twentieth century. Children were placed in a range of institutions including orphanages, homes and industrial or training schools that were administered variously by the state, religious bodies and other charitable or welfare groups (ASCARC 2004).

Involuntary treatment

When a person is being treated for their illness without their consent and under mental health legislation, either in hospital or in the community. This may occur when mental health problems or disorders result in symptoms and behaviours that lead to a person's rights being taken away or restricted for a period of time (National Mental Health Commission 2012).

Lived experience

The experience people have of their own or others' mental health issues, emotional distress or mental illness, and of living with, and recovering from, the impacts and consequences of their own or others' mental health issues, emotional distress or mental illness.



Mental health practitioner

A worker within a mental health service who provides treatment, rehabilitation or community health support for people with a mental illness or psychiatric disability (adapted from *National Standards for Mental Health 2010*). See also 'Mental health services'.

Mental health services (MHS)

Services with the primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function (adapted from *National Standards for Mental Health Services 2010*).

Mental health service system

The mental health service system comprises services and programs in which the primary function is to provide promotion, prevention, early intervention, medical and psychiatric treatments and recovery support for people who experience mental health issues or mental illness, and/or their families, carers and support networks.

Mental illness

Disturbances of mood or thought that can affect behaviour and distress the person or those around them, so the person has trouble functioning normally. They include anxiety disorders, depression and schizophrenia (National Mental Health Commission 2012).

Peer support

People with a lived experience of mental health issues support each other in their recovery journey. Support may be formal or informal, voluntary or paid. It may be stand-alone support or part of an initiative, program, project or service, which is run either by peers themselves or by professional mental health service providers.

Personal recovery

Defined within Australia's national framework for recovery-oriented mental health services as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues. See also Clinical recovery.

Practice domain

A field of practice.

Psychiatric advance directive

A written document that describes what treatment a person does or does not want if at some time in the future they are judged to be incapacitated from mental illness in such a way that their judgement is impaired or they are unable to communicate effectively. Typically it includes instructions about treatment options or designates authority for decision making (adapted from Washington State Department of Social and Health Services 2013). It is currently not legally binding in Australia. Also known as a mental health advance directive, advance agreement, or a Ulysses agreement in disability services.

Recovery

See Personal recovery and Clinical recovery.

Recovery-oriented practice

The application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.



Recovery-oriented service delivery

Evidence-informed treatment, therapy, rehabilitation and psychosocial support that aim to achieve the best outcomes for people's mental health, physical health and wellbeing (Victorian Department of Health 2011a).

Restraint

Restraint is the restriction of an individual's freedom of movement by physical or mechanical means. This applies to consumers receiving specialist mental health care regardless of the setting (National Mental Health Seclusion and Restraint Project 2007–2009).

Seclusion

Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented (National Mental Health Seclusion and Restraint Project 2007–2009).

Self-determination

The right of individuals to have full power over their own lives. Self-determination starts with the basic ideas of freedom to design a life plan, authority to control some targeted amounts of resources, support that is highly individualised and opportunities to be a contributing citizen of the community (Nerney 2000).

Self-management

When people are in direct control of managing their mental health conditions. Self-management approaches focus on enabling the person to solve problems, set goals, identify triggers and indicators of deteriorating health, and respond to these themselves instead of always relying on clinician-led intervention. The common theme is a structured approach that develops over time and through experience (Crepaz-Keay 2010).

Sensory modulation

Involves supporting and guiding people (often in a designated sensory room) to become calm or shift an emotional state by using sensory tools such as sights, sounds, smells and movement, or modalities such as weighted blankets or massage chairs (Te Pou 2013).

Stolen Generations

Aboriginal and Torres Strait Islander Australians who were forcibly removed, as children, from their families and communities by government, welfare or church authorities and placed into institutional care or with non-Indigenous foster families (National Mental Health Commission 2012).

Trauma

Very frightening or distressing events may result in a psychological wound or injury or a difficulty in coping or functioning normally following a particular event or experience (Australian Psychological Society 2013). Also known as psychological trauma. Trauma can occur in individuals or collectively in communities. Trauma can also be transmitted from one generation to the next. Trauma can lead to serious long-term negative consequences.

Ulysses agreement

See Psychiatric advance directive.

Values-based practice

Derived from philosophical value theory and phenomenology, values-based practice complements evidence-based clinical practice in mental health care. It provides practical tools to support clinical decision making when complex and conflicting values are at play (Fulford & Stanghellini 2008).



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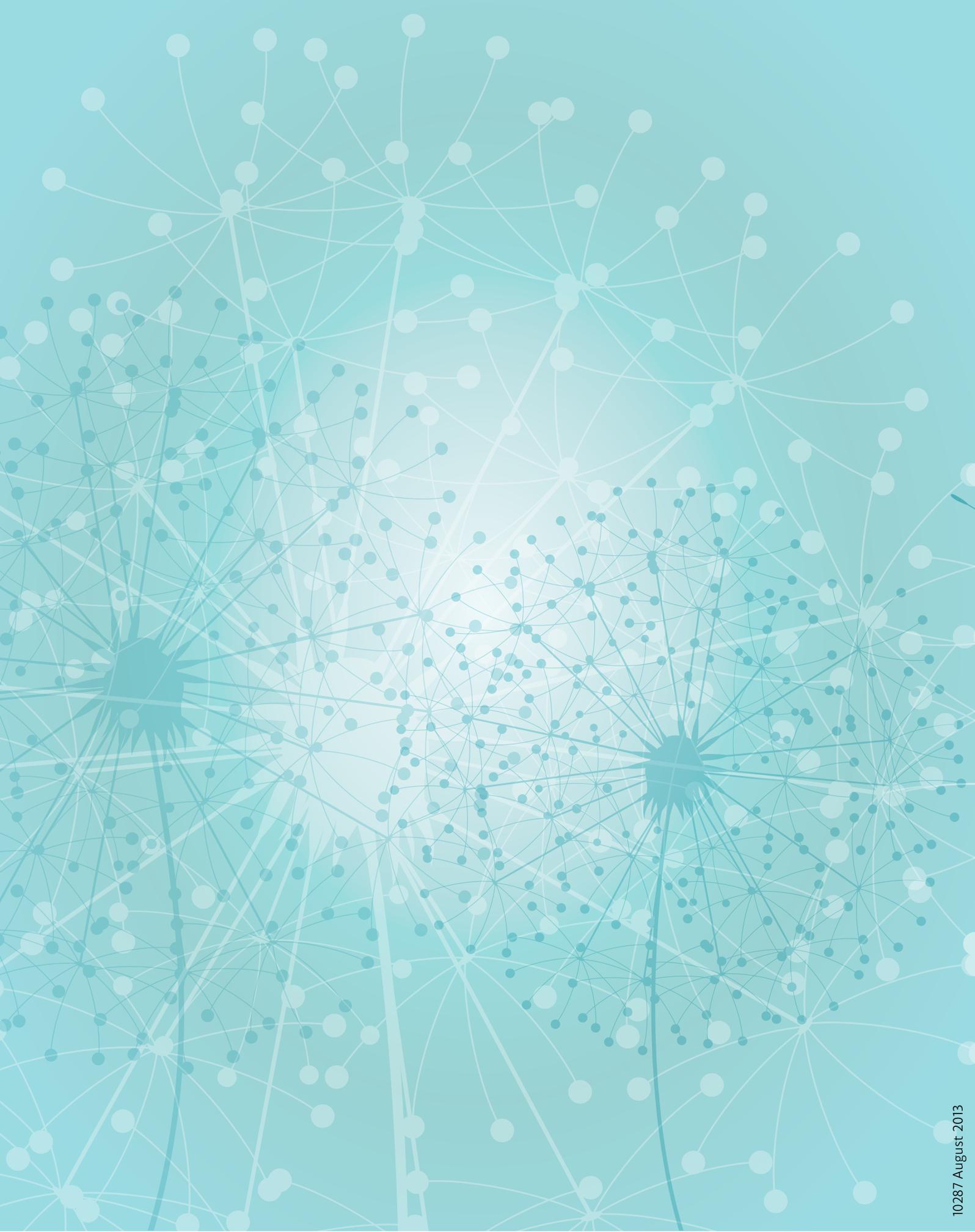


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All information in this publication is correct as at August 2013