Approaches that support recovery, including through peer support

A Literature Review/backgrounder
for the chapter *Ensuring Effective Support, Care and Treatment,*
Report Card on Mental Health and Suicide Prevention 2013

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Approaches that support recovery - A contributing life

A Fulfilling Life

It was 1982 in a dark and dingy room in an old institution. I was being assessed as to whether it was safe to discharge me after my second manic attack in less than two years. Royal Park has produced two great names in psychiatry, John Cade and Pat McGorry but this consultant psychiatrist would never be one. He pronounced that I would leave the hospital, be on a pension and living in public housing for the rest of my life. If my experience of the distress associated with my bipolar diagnosis wasn't enough, this 'sentence' nearly destroyed me – I was twenty-eight at the time. Fortunately, my Jesuit education had taught me two things: my sense of social justice and to meet a challenge head on and know that I could win.

My mother, a doctor, disagreed with the prognosis and she facilitated my recovery journey, years before the great work of Pat Deegan and Bill Anthony. I was allowed to make my own mistakes and to take 'risks' for this was how I would learn. By this stage, I had fallen into a debilitating depression, however, work was very important to me. My first job was to clean out the kennels at an animal shelter. Within a decade, I was heading up a US multinational in Australia and parts of Asia. It was during this period that I felt my journey could assist my peers and so I resigned and went to work in mental health.

A number of people have been very influential in what people see as my success and Gerry Naughtin, CEO, Mind Australia is one such person. Gerry had come to Mind from outside the mental health sector and so he had a fresh focus including of the lived experience. Others who have supported me are my partner Edo, my friend, colleague and mentor, Larry Davidson, David Castle and many others. They have all enabled systemic and cultural change. I have always found, that to facilitate change, it is important to include and respect everyone's opinion and to avoid polarising. A formula that I use is that each morning at 5am I think of my day ahead and how it will benefit the people I serve. At 7pm each night, I reflect on my day and ask the same question. This avoids politics, ego and keeps me focused.

So what do I do? I am the Senior Advisor Recovery at Mind; an Honorary Fellow in the Department of Psychiatry and an Honorary Fellow in the School of Population and Global Health, University of Melbourne; a Visiting Scholar Yale University School of Medicine and a consultant to the NSW Mental Health Commission. With a colleague and friend, we wrote the Peer Support Training Manual that received a TheMHS Achievement Award this year. I also have written and I deliver the core modules on Recovery for the Master of Psychiatry/ Master of Psychological Medicine degree, accredited by the RANZCP. I have mentored Dr Steve Harrington, at the request of the US Department of Health, in his role as Chair of the committee setting peer practice standards in the US. Larry Davidson and myself are now co-chairing an international steering committee setting Global Peer Practice Standards. Finally, I have worked in Indonesia for over six years introducing recovery-oriented practice.

My work is my vocation

Anthony Stratford

Introduction/Executive Summary

This report *Approaches that support recovery, including through peer support,* has been prepared for the National Mental Health Commission, as background for its 2013 Report Card.

The report provides a summary of the peer-reviewed and other literature around mental health recovery and overviews trends in recovery-oriented practice internationally and in Australia. It summarises practice for people in recovery and their supporters, as well for services in both government and non-government sectors. Examples of these are outlined to demonstrate some of the areas of good practice around the country.

The literature overall is prolific in the area of recovery and peer support. There is great enthusiasm and commitment, a growing number of policy documents and some impressive activity (albeit ad hoc), especially in the non-government sector. However, while there are a number of academic papers that provide an evidence-base for work in this area, particularly for peer support, as yet this is of limited breadth and availability. Also, there is a shortage of peer-reviewed literature providing strong evidence as to effectiveness of a wide range of interventions. This should change over the next few years as the need for funding robust outcome studies is acknowledged by government and other bodies.

Most of the material in this report is accessed from previous literature reviews, reports, policy and planning documents and a multitude of web sites. It builds and draws upon a number of seminal works in the area – the National Recovery-oriented Mental Health Practice Framework [1], prepared by Craze Lateral Solutions, the 2009 Literature review on Recovery [2], prepared by the NSW Consumer Advisory group, *Supporting and developing the mental health consumer and carer identified workforce – a strategic approach to recovery* [3], prepared by the National Mental Health Consumer & Carer Forum, as well as the growing number of background and policy documents from the United States of America (USA) and the United Kingdom (UK). Face to face and telephone discussions were also held with a selection of key stakeholders – Appendix 1. The time available for this report means an exhaustive study was not possible and inevitably there will be omissions. This does not imply that any documents, services or programs that are not mentioned here are unworthy.

However, the literature is unambiguous – the concept of mental health recovery is here to stay and the benefits of peer support are clear. The challenge is to ensure that stakeholders share the same vision and are respectful of the people and processes required to reach it.

Section headings

1. What is recovery?

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again... The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution. [4]
Pat Deegan - an activist in the disability rights movement in the USA.

Recovery is at its core a personal journey, which requires services to foster our personal resourcefulness, reconnect us to our natural supports and facilitate our equal opportunities. In other words recovery-based services support the restoration of a person's existential 'being' and social 'belonging' after these anchors have been cut adrift by mental distress. Mary O'Hagan [5] – NZ Commissioner

Over the past 30 years there has been a revolution in mental health – particularly in the area of more severe mental illness.

A recovery approach, pioneered in the USA [6] by people with lived experience of mental illness, who recognised that many people can and do recover, is now seen as the key organising principle underlying mental health services in most developed [7] countries around the world. There is general agreement [8] internationally [9] that early intervention and the recovery approach lie at the heart of most international reform programs, supported by the growing body of evidence that suggests these are key aspects of success.

The recovery movement evolved from the civil rights and disability sectors, which have a long tradition of advocating for restoration of civil rights and full inclusion in community life. According to the (Australian) National Standards for Mental Health Services 2010 [10], a recovery approach in mental health services is now clearly acknowledged as promoting and protecting individual's legal, citizenship and human rights.

There are many definitions of recovery [8], but at its heart is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life. A central tenet of recovery is that it does not necessarily mean cure (clinical recovery). Instead, it emphasises the unique journey of someone living with mental health problems to build a life for themselves beyond illness (social recovery). Thus, a person can recover their life, without necessarily 'recovering from' their illness. That is, people can live, love, work and play in their community, doing the 'normal' things that people need to do or enjoy doing every day.

In the late 1990s, both New Zealand [11] (through its mental health commission) and the USA [6], (through the 1999 Surgeon Generals Report on Mental Health and the 2003 President's New Freedom Commission), identified recovery as the most important aim of services. This approach puts the person living with mental illness, front and centre in their recovery.

In Australia, health ministers endorsed a new *National Mental Health Policy* [12] in December 2008. The Policy gave a vision for mental health in Australia, which emphasised recovery:

... a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

The Australian National Mental Health Recovery Framework,[1] starting with the initial assumption that personal recovery is different for everyone, defines 'personal recovery' simply as *being able to live well and to build and live the life one chooses in the presence or absence of mental ill health*.

There is general consensus within the mental health sector in Australia that recovery is a good idea and indeed is synonymous with the notion of a contributing life. However it is important that practice keeps pace with rhetoric. The intentions of the new National Mental Health Recovery Framework [1], to align with recovery principles the practice of all people working in the specialist mental health system, across clinical and non-clinical practice settings, in hospital settings or in the community, in government, non-government/not-for-profit and private sectors, is an important starting point. The Framework will be useless however, without any mandate for services to adhere to it.

Consumers and carers are driving change, with support from the non-government sector, policy makers, government initiatives and increasing numbers of health professionals. There is enormous goodwill. There are impressive programs internationally and there are patches of brilliance around this country. However, mental health services and professionals need help to dismantle the barriers to putting recovery principles and policies into practice from the very first contact with the mental health system. Funding for robust monitoring and evaluation of activities is also critical, in order to objectively demonstrate the cost effectiveness of this approach.

For recovery to have the impact it truly deserves, it is important that clinicians understand what recovery means and together with consumers and others, actively support its implementation across services. Culture change is required for services to become positive and hopeful places, where people are welcomed, supported and enabled to make decisions about which treatments and other services are best for their recovery. A workplace where peer workers are welcomed and supported as valued colleagues.

There is great need to introduce sound infrastructure for the consumer and carer peer workforce, so that education, training, supervision and funding structures are standardised. Professional practice standards such as those developed by the International Association of Peer Supporters[13], which include practice guidelines, core competencies and ethical guidelines, are needed as with any other professional workforce.

Beyond the mental health sector there is also much work to be done to ensure that interfacing sectors such as housing, education and employment, also understand and implement recovery-oriented practice so that people with mental illness have the best opportunities and supports for the best life they can lead as determined by them [14].

2. An overview and summary of national and international trends in best or good practice

Approaches that support recovery are described differently by different groups, however they all share common values and principles.

For the purposes of the Australian Recovery Framework [1], recovery oriented practice is understood as encapsulating mental healthcare that:

- Maximises self determination and self management of mental health and wellbeing and involves person first, person centred, strengths based and evidence based treatment, care and support that acknowledges and validates diversity 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 illness and their families including housing, education, employment, income, isolation and geographic distance, relationships, social connectedness, personal safety, trauma, stigma, discrimination and socio economic hardship

- Assists families to understand the challenges facing their family member, recovery processes and how the family might assist in supporting the individual's recovery whilst also assisting families with their own needs for counselling, therapy, education, training, guidance, support services, peer support and advocacy.

In the USA, SAMHSA's *Recovery Support Strategic Initiative* [15], has outlined 10 Guiding Principles of Recovery

1. Recovery emerges from hope
2. Recovery is person-driven
3. Recovery occurs via many pathways
4. Recovery is holistic
5. Recovery is supported by peers and allies
6. Recovery is supported through relationship and social networks
7. Recovery is culturally-based and influenced
8. Recovery is supported by addressing trauma
9. Recovery involves individual, family, and community strengths and responsibility
10. Recovery is based on respect

In the UK, the British policy paper *Making Recovery a Reality* [8], outlines the components simply as:

- Finding and maintaining hope – believing in oneself; having a sense of personal agency; optimistic about the future;
- Re-establishment of a positive identity – finding a new identity which incorporates illness, but retains a core, positive sense of self;
- Building a meaningful life – making sense of illness; finding a meaning in life, despite illness; engaged in life;
- Taking responsibility and control – feeling in control of illness and in control of life.

The broader approaches needed to promote recovery reform in mental health services, have been outlined by Prof Larry Davidson [16], one of the leading researchers in recovery work:

- Decrease stigma, discrimination, and other barriers to access to care
- Facilitate early identification and ensure timely access to early intervention
- Utilize practices that are effective (i.e. that are evidence-based)
- Rethink the relationship of care to recovery, and the role of practitioner
- Shift focus from what we can't change to what we can
- Learn from people in recovery

There is agreement that stigma is an enormous barrier to accessing effective treatment and support and much more needs to be done in this area. The Australian government has made clear commitment to early intervention for first episodes through its support for Headspace and EPPIC programs. However, active and meaningful involvement of consumers, wherever possible in leadership roles, is also essential for this broader work. For example, consumers' involvement in community awareness/education and stigma reduction [17] activity and in professional education and training [18] will provide positive role models and enhance early intervention, effective treatment and support services.

Approaches can be grouped into those involving peer support and those needing systemic change.

2.1. Consumer/peer support

Peer support refers to services provided by and for people who have similar life experiences. Peer support can take many forms, including support groups, one to one mentoring, crisis houses, support in employment and creative activities and so on. Peers can potentially provide any types of support services. It's not so much what peers provide that makes the difference, but who provides it and how. Peer support is unique in its ability to foster equality and mutuality, including the use of positive self-disclosure and role modelling to develop trust, express empathy and convey hope [19].

The dominant trends internationally [20] and nationally [10] are for greater involvement of peer workers, development of peer run programs, the introduction of professional standards for recovery work, development of tools and scales for measuring recovery. There is also attention to evaluation – to demonstrate the value of recovery-oriented programs for consumers, peer workers, mental health professionals and mental health services/programs. Cost-effectiveness studies are also starting to emerge [21].

Evidence on the benefits of peer support [22] in mental health has developed rapidly in the last decade. Benefits such as raised empowerment, reduced social isolation, substance and health services use, improvements in social functioning, empathy and acceptance, reduced stigma and increased hope. Over time, the addition of trained peers has also been shown to improve the subjective quality of the service, reduce coercion and the use of physical restraints [23]. While not all studies show all these benefits, it depends a lot on how well the peer support workers are selected, trained and supported and how well the organisation is prepared. Everyone benefits:

a. Benefits to the worker

I work hard to keep myself well now, I've got a reason to look after myself better... It's made a real big difference to me, you know, contributing something to them and hopefully changing their lives for the better.

b. Benefits to the people being supported

Peer workers have the time and flexibility to listen. They always take the time to talk, whereas other staff members may get called away.

c. Benefits to the teams in which they work

I just stand back and watch him work his magic. Not just with the patients who come in here so frightened and hopeless, but with staff too. He can help them see things in a completely different way. Peer workers have significantly changed the recovery focus of our team; they challenge the way we talk about people from a problem and diagnosis focus to one of strengths and possibilities.

d. Benefits to the organization

Values and leadership of consumers are driving the shift from a system focused on symptom reduction and custodial care to self-directed recovery built on individual strengths.

A recent British study [21], looking specifically at whether peer support workers can reduce psychiatric inpatient bed use, either by preventing admissions or by shortening lengths of stay, found that the financial benefits of employing peer support workers do exceed the costs, in some cases by a substantial margin. The authors conclude that while the evidence for this finding is very limited in both quantity and quality, it nevertheless justifies continuing interest in the employment of properly trained and supported peer workers in mental health teams, alongside more research evaluating their effects.

National and international trends are for increasing numbers of peer support workers to be employed in a variety of ways and settings. In the USA, it has been reported that services run for and by people and their families with serious mental health problems now number more than double traditional, professionally run, mental health organisations [22]. In 2010, in some of its mental health services, almost ¾ of Recovery Innovations staff [24] are trained and supported peer workers. It is estimated that 40% of the mental health workforce in the USA are peer workers. In Nottinghamshire [25] in the UK the aim is for at least 2 peer workers in every team.

In the USA, peer work has advanced to the stage where the Center for Medicare and Medicaid Services [26] now recognises peer support providers as a distinct provider type for the delivery of support services and considers it an evidence-based mental health model of care. Georgia and Arizona were among the first states to be approved for Medicaid coverage of Certified Peer Specialists [27] (CPS). The CPS does not replace other mental health professionals, but rather is a complement to an array of mental health support services.

SAMHSA has also identified consumer-operated services (COS) – including peer work – as evidence based practice (EBP), and a COS EBP ToolKIT [28] has been developed.

In Australia consumers and carers have been employed for some years now but in more restricted ways. The NMHCC Forum [3] says that when consumer and carer identified positions are well designed and are integrated into flexible and supportive workplace environments, these workers can use their knowledge and skills to deliver:

- targeted peer support and mentoring to consumers and carers
- extensive knowledge of what life is like for consumers and carers and the capacity to link traditional mental health care with the community, providing an essential holistic and recovery focused element to traditional mental health service delivery
- role models for recovery for consumers, carers and the mental health workforce, as well as colleagues based outside mental health services (e.g. police, criminal justice), challenging discriminatory consumer and carer stereotypes and helping to break down stigma
- advocacy at both individual and systemic levels
- valuable policy input

Issues are emerging in the literature and in discussions, however, about the challenges faced by both peer workers and mental health services as they evolve to recovery-oriented services. There is a lack of consensus [29] about peers' core competencies combined with unclear or unsuitable job descriptions, which leaves peers uncertain about their own job performance. Low wages, inappropriate expectations and/or tokenism and a lack of support networks can lead to re-traumatisation, exploitation and burnout.

The NMHCC Forum has also described how the tensions inherent in these roles have not been adequately addressed, resulting in burnout, lack of trust and respect between consumers, carers and clinical staff and compromised health outcomes for the consumers and carers who use these services. Peers are concerned about the lack of training and of peer-focused supervision and support. Much remains to be done to support mental health services and non-peer workers to help bring about systemic change.

2.2. Systemic change

Within any kind of service, transformation requires a whole new set of attitudes, values, relationships, explanatory theories, models of practice and organisational structures. Our mental health services transformation must be built upon the recovery philosophy, which focuses on hope, self-determination, active citizenship and a holistic range of services. Destination: Recovery [30]

The literature is clear that systemic change is needed for recovery approaches to work and that consumer and carer-identified positions need to be supported as part of a strategic approach to improving the culture of mental health workplaces so they can take up their most effective roles.

The Victorian Recovery Framework [31] clearly acknowledges the need for change in practice for service delivery to be recovery-oriented. In particular, the need for strong partnerships in decision-making and for collaborative practices across the full spectrum of service provision, from assessment and acute treatment to therapeutic programs, long-term rehabilitation, accommodation and employment. In response to criticism of a recovery approach about failing to address the issue of risk, the Framework acknowledges that a degree of risk tolerance is necessary.

Consumers themselves know what is helpful from mental health services and workers in their recovery. UK user/consumer led research [32] recommends, amongst other things, that practitioners and services:

- Acknowledge the fact that service users' understandings of recovery are personal and varied and work with those concepts of recovery
- Work with individual service users to find the way(s) of understanding mental distress that prove most useful to them, rather than offering solely medical explanations
- Allow for the fact that personal qualities that mental health professionals bring with them are as important to service users as actual services
- Use treatment options to help services users live lives that they find meaningful, rather than as an end in themselves, and make fuller use of holistic approaches that any one service user says assists recovery

A qualitative study [33] of 15 consumers identified common factors about helpful relationships. Professionals who conveyed hope, shared power, were available when needed, were open regarding the diversity in what helps, and were willing to stretch the boundaries of what is considered the ''professional'' role, were valued. The study concluded that 'Recovery-oriented professionals were those who had the courage to deal with the complexities and the individuality of the change process, and were able to use their professional skills and expertise in a collaborative partnership with the service user.

An Expert Panel [34] convened by SAMHSA in 2012, to learn more about and develop responses to the needs of behavioral health systems and authorities as they strive to promote and support peer services, came up with the following recommendations:

- Develop clear guidelines and best practice recommendations for peer recovery support services in behavioral health programs
- Create resources that assist States and authorities to develop, monitor, and finance peer support/recovery coaching services
- Encourage further research to establish the evidence base of peer support/recovery coaching
- Strengthen training in peer support/recovery coaching and continue to promote the benefits of certification
- Celebrate and strengthen the bonds between the mental health and addiction fields

There is healthy discussion about recovery as the guiding principle for service delivery in Australia and the challenges implementation of this approach may bring to services [35]. Most people in the sector now understand that recovery has a different meaning from the traditional view that recovery means return to previous state. However, some lack of consistency [36] in the way in which recovery is viewed. It is important there is a shared understanding of recovery by all parties and that non-peer workers need support. The top 10 concerns [37] held by clinicians about recovery, may now be starting to fade, but these concerns still exist.

Top ten concerns about recovery in serious mental illness

1. Recovery is old news. "What's all the hype? We've been doing recovery for decades."
2. Recovery-oriented care adds to the burden of mental health professionals who already are stretched thin by demands that exceed their resources. "You mean I not only have to care for and treat people, but now I have to do recovery too?"
3. Recovery means that the person is cured. "What do you mean your clients are in recovery? Don't you see how disabled they still are? Isn't that a contradiction?"
4. Recovery happens for very few people with serious mental illness. "You're not talking about the people I see. They're too disabled. Recovery is not possible for them."
5. Recovery in mental health is an irresponsible fad. "This is just the latest flavor of the month, and one that also sets people up for failure."
6. Recovery only happens after, and as a result of, active treatment and the cultivation of insight. "My patients won't even acknowledge that they're sick. How can I talk to them about recovery when they have no insight about being ill?"
7. Recovery can be implemented only through the introduction of new services. "Sure, we'll be happy to do recovery, just give us the money it will take to start a (new) recovery program."
8. Recovery-oriented services are neither reimbursable nor evidence based. "First it was managed care, then it was evidence-based practice, and now it's recovery. But recovery is neither cost-effective nor evidence based."
9. Recovery approaches devalue the role of professional intervention. "Why did I just spend ten years in training if someone else, with no training, is going to make all the decisions?"
10. Recovery increases providers' exposure to risk and liability. "If recovery is the person's responsibility, then how come I get the blame when things go wrong?"

Encouragingly, professional groups worldwide are embracing the concept of recovery.

- The new Australian Mental Health Professional Online Development MHPOD [38] online learning resource developed for people working in mental health, is based on the national practice standards for mental health, and includes recovery as one of the key topics.

- A recovery framework is clearly articulated in the ACMHN Standards document [39], and since 2001 there has been a consumer perspective academic position [40] in the Center for Psychiatric Nursing Research and Practice at the University of Melbourne, to provide a consumer perspective and encourage greater consumer participation in the education of postgraduate psychiatric/mental health nursing students. The Consumer academic also collaborates with other consumers and academic staff in research, and is actively building networks of consumer thinkers and leaders.

- The RANZCP Strategic Plan 2012 – 2014 [41], lists a key value of being committed to early intervention and recovery and recovery-oriented training is now being introduced into psychiatric registrar training [42] in some places with the training being delivered by a peer worker. The World Psychiatric Association has a Project on Partnerships for Best Practices in Working with Service Users and Carers [43] and a position statement on recovery [44] by British psychiatrists outlines the importance of supporting the needs and wishes of mental health service users to live a more fulfilling life and to giving greater emphasis to the social outcomes of people with mental health problems.

Comprehensive and impressive practice frameworks are being developed in Australia and internationally and practical steps are now being taken to base services and programs on a recovery model. Practical guides are also being developed. In the UK the national mental health organisation Rethink has published a Guide for health workers and organisations *100 Ways to support recovery* [45]. SANE Australia has recently launched a resource for mental health professionals, which looks through a recovery lens at how to support people experiencing suicidal thoughts *Suicide Prevention and Recovery Guide* [46].

For real recovery approaches to be implemented, it is not just coalface workers who need to change. There is also a need to fundamentally transform the leadership culture [47] of organisations and teams. Experience is showing that leaders need to relinquish some of their expert status and work in a coaching and collaborative style, as the term recovery refers to a significant shift away from a paternal approach or substitute decision-making model, such that people with a mental illness are encouraged and supported to make their own decisions where possible.

3. Current policy directions – National, State and Territory

3.1 National

Current policy directions at both national and jurisdictions consistently reinforce a recovery-orientation in services, including peer support. The *Fourth National Mental Health Plan* [48] lists Social inclusion and Recovery as Priority area 1. One of the main actions is to adopt a recovery-oriented culture underpinned by appropriate values and service models.

The Plan calls for the establishment of a certified peer specialist workforce and expansion of opportunities for meaningful involvement of consumers and carers and it also intends that the attitudes and expectations that underpin a recovery focus, are also taken up by clinical staff within the public and private sectors — both bed based and community based. This will strengthen the partnership and sharing of responsibility between the consumer, their families and carers, and service providers.

A range of Commonwealth government initiatives is underway:

- FAHCSIA
  - Personal Helpers and Mentors (PHaMs) program
  - Mental Health Respite: Carer Support
- Department of Health and Ageing
  - Consumer and carer participation
  - Partners in Recovery
  - Support for Day to Day Living in the Community
- Development of the Australian National Standards for Mental Health Services (2010)
- Development of a National Recovery Framework
- Peer workforce activities document
- Development of resources for Cert 4 in Training qualification for peer workers

3.1.1 FAHCSIA

Through the Targeted Community Care (Mental Health) Program [49], FaHCSIA delivers community mental health services. These services are:

Personal Helpers and Mentors (PHaMs) program

Personal Helpers and Mentors [50] is an initiative funded under the COAG National Action Plan administered by FaHCSIA, which funds non-government organisations (mental health and other NGOs), to assist people whose lives are severely affected by mental illness.

Through PHaMs people aged 16 years and over are assisted with recovery by helping them to overcome social isolation and increase their connections to the community. People are supported through a recovery-focused and strengths-based approach that recognises recovery as a personal journey driven by the participant.

Early evaluation of the program has found that Personal Helpers and Mentors (PHaMs) is seen as highly effective by clients and all stakeholder groups and it has made visible contributions to those with severe and persistent illness. Minor evolution in the program design and funding levels would substantially increase its effectiveness.

The 2011–12 Budget allocated an additional $154 million over the five years to 2015–16 for new and/or expanded PHaMs services to assist around 3,400 people with severe mental illness, through the engagement of 425 new personal helpers and mentors.

Of this funding, $50 million is allocated to assist up to 1,200 people with a mental illness who receive the Disability Support Pension or other Government income support payments and are participating in, or willing to engage with employment services. PHaMs support will help these people address personal, non‑vocational barriers to their participation in work or training.

In April 2013, the government announced a $121 million spending boost to pay for 230 personal helpers and mentors to work one-to-one with people with a disability.

Case study - how PHaMs has helped kick-start peer workers in the NGO sector

Neami National Peer workers

Neami now employs thirty-five peer support workers. We commenced employing peer support workers just over three years ago. Thirteen of these are funded through the PHaMS, but the success of the initiative has prompted Neami to convert other support work positions to peer work roles. Peer workers have a clear and distinct role within Neami supporting engagement, facilitating recovery and wellness planning groups, and supporting engagement with the organisation. A recent staff survey confirmed the value this has brought to teams, and consumers invariable nominate their encounters with peer workers as providing hope and inspiration to them in their recovery journey. Neami has implemented a range of strategies to support the effective use of peer workers:

- Change management approach to the introduction of peer workers at service sites
- Clear role and function within the services
- Tailored training for both managers and peer workers
- Opportunities for peer workers to network and provide peer supervision
- Regular review of how it's working

We believe that access to peer facilitated programs is an integral part of a recovery oriented service and are committed to contributing to expand our peer workforce

Comment

The principles underlying PHaMs, including mutual respect, empowerment of participants, collaboration between key partnerships and involvement of participants, families and carers in service planning and evaluation, are consistent with current thinking:

Participants have individual recovery plans (IRP), tailored to their needs and which are central to effectiveness of the program.

Emerging issues and concerns include differences with selection criteria for participation in each PHaMs, which means that a person who moves to another area may not be eligible for a PHaMS program. Many PHaMs workers are consumers – a minimum requirement is that 1Equivalent Full Time worker is employed. There is a lack of clear standardised job descriptions, training programs, supervision, and pay rates for workers. FAHCSIA is aware of these issues.

Mental Health Respite: Carer Support (MHR:CS)
MHR:CS [51] provides assistance for carers of people with mental illness to help them maintain their caring roles and improve their wellbeing.

In 2011–12 a total of 190 MHR:CS services funded for $50.3 million, assisted over 28,000 carers of people with mental illness in Australia. The 2011–12 Budget allocated an additional $54.3 million over the five years from 2011–12 to 2015–16 for new or expanded MHR:CS services to assist carers of people with mental illness. The rollout of new services is taking place in 2013.

This round of funding will assist up to an additional 1,000 carers and families of people with mental illness by providing greater access to a broad range of supports. New or expanded MHR:CS services will focus on improving access to a broader range of carer support options that account for the episodic nature of mental illness and the need for carer support services that respond to changing circumstances. New services will be expected to deliver a range of services that can include providing breaks for carers from their caring roles, social and recreational activities, counselling, education, advocacy and referral, and education for families and the community about mental illness and its impacts.

Comment
This is a new program in the establishment phase. While there is strong evidence of need for the program it is too early to have any measures of efficacy.

3.1.2 Department of Health and Ageing (DOHA)

Consumer and carer participation
The important role of mental health consumers and carers in the development, implementation and evaluation of policies, programs and services is recognised and supported by all governments under the National Mental Health Strategy. DOHA and state and territory government departments fund the Mental Health Council of Australia (MHCA) to auspice the National Mental Health Consumer and Carer Forum [52] (NMHCCF). This funding supports consumer and carer participation in policy and program development at a national level.

The department also funds the MHCA to operate the National Register of Mental Health Consumer and Carer Representatives [53]. The register complements the NMHCCF and provides access to a wider number of representatives for national level activities. The register also provides its members with opportunities for further development and networking.

The 2011-12 federal budget package, *Delivering National Mental Health Reform* [54], included the commitment to create a new national mental health consumer organisation. Once established, the national mental health consumer organisation will be dedicated to involving a diversity of mental health consumer groups, organisations and individuals, and representing a wide cross-section of experiences and views, in particular those views which are often under-represented. A Mental Health Consumer Reference Group has been convened to provide advice to the MHCA on planning and implementation of the new organisation.

The new organisation will provide a strong and consolidated consumer voice to contribute to more responsive and accountable mental health reform. This will include complementing the work of the National Mental Health Commission that is assessing system performance.

Comment
While acknowledging the sensitivities and the goodwill involved in establishment of the new national mental health consumer organisation, there are concerns that progress to date is too slow.

Partners in Recovery: coordinated support and flexible funding for people with severe and persistent mental illness with complex needs (PIR)

In the 2011-2012 federal budget, the Commonwealth government committed additional funding to create the *Partners in Recovery* [55] *(PIR)* program, also known as *Coordinated Care and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Care Needs.*

PIR is designed to respond to the service needs of people with severe and persistent mental illness, and complex support needs, which require a response from multiple agencies. It has been estimated the program will assist around 24,000 people (from mid-20s years of age and up) Australia wide. These individuals typically have persistent symptoms, significant psychosocial disability, are disconnected from social or family support networks and rely on a range of health and community services to maintain living in the community. They may have comorbid substance use and/or physical health issues, are likely to have difficulty in maintaining stable accommodation, and managing everyday living demands.

The PIR initiative aims to:

- facilitate better coordination of clinical and non-clinical services to deliver 'wrap around' support to meet the full range of an individual's needs
- improve referral pathways and strengthen partnerships with existing services
- further embed a community based recovery model of support and service delivery throughout the mental health and related sectors
- adopt a 'no wrong door' approach to service access and referral.

The PIR program is being implemented through Medicare Locals, in partnership with local providers to deliver this service.

So far, lead organisations in 49 of the 61 Medicare Local regions are ready for stage one of the Partners in Recovery rollout, with further work occurring in the remaining regions.

Comment
This is a new program in the establishment phase, so it is too early to make an assessment of efficacy. While elements of the program seem to be consistent with recovery principles, and the program was developed in consultation with consumers and carers as well as other stakeholders, no evidence base is referred to. Partnerships are extensive, no two programs will be the same and the federal state interfaces, as with all commonwealth initiatives will need to be carefully managed. Close monitoring of efficacy will be essential.

Support for Day to Day Living in the Community

The Support for Day to Day Living in the Community [56] (D2DL): A Structured Activity Program provides funding to improve the quality of life for individuals with severe and persistent mental illness by offering structured and socially based activities. The initiative recognises that meaningful activity and social connectedness are important factors that can contribute to people's recovery. A key objective of the D2DL Program is to expand the capacity of the non-government sector to offer structured day programs.

The Department of Health and Ageing funds 40 organisations at 60 sites around Australia to provide structured and socially based day activities. These organisations provide a wide range of activities, based on client needs.

These activities include, but are not limited to cooking classes, bushwalking, gym and swimming classes, vocational activities such as volunteering groups, return to work skill development groups, computer classes, trips to local TAFEs and neighbourhood houses to explore study options, arts, such as drama, drawing, pottery, creative writing, painting classes and social outings.

Evaluation of the program in the first 2 years showed that D2DL appeared to have achieved its objectives and over 7,000 places had been created in each year. Discussions with service providers and consumers, along with a review of progress reports, indicated that the intended target group had been reached. Discussions with consumers identified a number of factors they considered were essential for their engagement, such as:

- provision of a safe environment free of aggression, harassment or intimidation
- involvement in the development of the range of activities, groups and outings – including activities to promote physical health
- opportunities and support to participate in decision making within the organisation
- an identified worker to discuss issues and support planning
- support to access external services such as education, vocational training, transport and recreation
- a structured program with activities scheduled well in advance
- financial support to participate in activities.

Engagement of young people, Aboriginal and Torres Strait Islander people and those from CALD backgrounds had been difficult for most services. Establishing links with organisations or services that had effective connections with these groups appeared important for D2DL services to attract these client groups. Over the life of the evaluation, it appeared that consumers at the sites visited had developed confidence and increasingly took ownership of the services.

A website [57] has been set up as a meeting place for mental health service providers delivering Day to Day Living (D2DL) programs around Australia.

Comment:
No mention is made of the role of peer workers or Consumer positions in the background information. Also, it is unclear from the website what the future holds for this program.

3.1.3 Australian National Standards for Mental Health Services Supporting Recovery Standard (Standard 10.1)

National Standards for Mental Health Services [58] have been developed for the broad range of mental health services. This includes bed based and community mental health services, those in the clinical and non-government sectors, those in the private sector and also those in primary care and general practice.

Standard 10.1 Supporting Recovery states:
The Mental Health Service incorporates recovery principles into service delivery, culture and practice providing people with access and referral to a range of programs that will support sustainable recovery.

The principles are all framed in recovery oriented mental health practice and criteria for the Mental Health Service reflect this:

- Actively supports and promotes recovery oriented values and principles in its policies and practices.
- Treats consumers and carers with respect and dignity.
- Recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities.
- Encourages and supports the self-determination and autonomy of consumers and carers.
- Promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination.
- Provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.
- Supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community.
- Demonstrates systems and processes for consumer and carer participation in the development, delivery and evaluation of the services.
- Has a comprehensive knowledge of community services and resources and collaborates with consumers and carers to assist them to identify and access relevant services.
- Provides access for consumers and their carer(s) to a range of carer-inclusive approaches to service delivery and support.

3.1.4 National Recovery Framework

The promotion and adoption of a recovery-oriented culture within Australian mental health services, is one of the key actions identified in the Fourth National Mental Health Plan (Action 4). This is being progressed by the Safety and Quality Partnership Subcommittee (SQPS) of the National Mental Health Standing Committee.

A national framework [1] for recovery oriented mental health service provision has been developed that spans all levels of service delivery to meet the needs of consumers, carers and the community. The framework is suitable for guiding national mental health system change. A most comprehensive Framework has been developed which has been signed off by all States and was launched in August 2013.

Specifically the intention of the Framework is to align with recovery principles, the practice of all people working in the specialist mental health system – across clinical and non-clinical practice settings, in hospital settings or in the community, in government, non-government/not-for-profit and private sectors.

Comment

This is a most comprehensive and exhaustive document, based on current evidence and thinking. One omission identified is the lack of a target for peer workers – 30% has been suggested to start with. While all States have signed off, sadly there is no mandate for services to adhere to the Framework.

3.1.5 Peer Workforce activities

Health Workforce Australia **(**HWA) is undertaking a mental health peer workforce [59] project to inform the national development of a mental health peer workforce model including advice on training, practice and other changes needed to establish a career pathway for mental health peer workers. The final report is due to be released in late 2013.

3.1.6 Certificate IV in Mental Health Peer Work

After many years of advocacy, the Certificate IV: Mental Health Peer Work [60] qualification and associated units, was endorsed by the National Skills Standards Council (NSSC) in May 2012. This course, which is designed around a recovery approach, enables peer workers to gain a recognised qualification, thereby greatly enhancing the recognition of peer support work across the sector.

This qualification covers consumer workers and carer workers who are employed within the mental health sector in government, public, private or community managed services. It is specific to workers who have lived experience of mental health problems as either a consumer or carer and who work in mental health services in roles that support consumer peers or carer peers.

Occupational titles may include:

- Consumer consultant
- Consumer representative
- Peer support worker
- Peer Mentor
- Youth Peer Worker
- Carer consultant
- Carer representative
- Aboriginal Peer Worker
- Participation Coordinator
- Family Advocate

The qualification has 6 core units and 9 elective units, some of which are separate electives for consumers and carers.

Comment

This is a most significant development as it marks the start of professionalisation of the peer workforce in Australia. Several organisations run Cert IV courses already and Community Mental Health Australia has received funding from the NMHC to develop resources for this course. Most of the resources, which are being developed by The Mental Health Coordinating Council in NSW, are due to be finalised in mid 2014, with the remaining due in early 2015.

3.1.7 Mental Health Commissions

As of July 2013, National, WA, NSW, Qld - all clearly articulate support for recovery approaches as a central tenet of their work and have appointed Commissioners and deputy commissioners with lived experience as consumers and carers.

3.2 State and Territory

All States and Territories have departments responsible for mental health, and recovery as a concept is incorporated into all plans and policy documents. All provide funding to non-government organisations for their recovery work. This section does not attempt to cover all relevant activity, but highlights and provides an outline of some of the more significant recovery work being undertaken in the area.

3.2.1 NSW

The NSW government has asked the Mental Health Commission of NSW [61] to develop a draft Strategic Plan for Mental Health in NSW. The draft Plan will be submitted to the NSW Government by March 2014.

The Plan will reflect the needs, wishes and priorities of people affected by mental illness – in all parts of the state and of all ages and cultural backgrounds. It also aims to encourage

psychological and social wellbeing across the whole of our community, and to recognise that mental health is a shared concern of many NSW Government agencies and the wider community. Importantly the Plan will embody ideas of autonomy and recovery – that is, supporting people to manage their own health, and live according to their own aspirations. Two of the 4 Deputy Commissioners have lived experience as consumers of mental health services and a Mental Health Community Advisory Council, with consumer and carer representation, has also been established.

3.2.2 Victoria

A Framework [31] for recovery-oriented practice, was developed in 2011 for the Department of Health.

Consistent with the literature, in this framework, recovery-oriented practice is understood as encapsulating mental healthcare that:

- encourages self-determination and self-management of mental health and wellbeing
- involves tailored, personalized and strengths-based care that is responsive to people's unique strengths, circumstances, needs and preferences
- supports people to define their goals, wishes and aspirations
- involves a holistic approach addressing a range of factors that impact on people's wellbeing, such as housing, education, employment, and family and social relationships
- supports people's social inclusion, community participation and citizenship.

Victoria is currently reforming [62] the Psychiatric Disability Rehabilitation Support Services sector to improve the recovery-oriented support for people with a mental illness. Renamed Mental Health Community Support Services, there will be a move to individualised client support packages, and clearer catchment boundaries will align, where possible, with Medicare Local Areas.

The *Mental Illness Research Fund*, a $10 million Victorian Government initiative aimed at supporting multidisciplinary and cross-sector collaborative research that has the potential to be translated into tangible improvements for Victorians with mental illness and their carers, has also been established. See also section 5.4

Comment
Victoria has a long history of strong community mental health services. System reform and re-commissioning of services is a major step and while there is a strong recovery focus, no explicit mention of peer support is made in early documents.

3.2.3 Queensland

The vision of the *Queensland Plan for Mental Health 2007-2017* [63] is to facilitate access to a comprehensive, recovery-oriented mental health system that improves mental health for Queenslanders. Queensland's first mental health commissioner started work in July 2013.

Previously the Queensland government has funded Intentional Peer Support (IPS) training and developed a Consumer Operated Services (COS) program as part of its investment in support services and accommodation in the community for people with a mental illness. The IPS and COS program are currently being evaluated [64].

The Recovery-Oriented Mentoring Project (ROMP)™ [65] was initially funded by Disability Services Queensland (DSQ) to provide Recovery oriented training and mentorship to leaders working within the mental health sector in both government and non-government services.

Comment
With current cutbacks in overall government spending in Queensland, early progress has stalled. It is hoped that establishment of a Mental Health Commission will get things moving.

3.2.4 South Australia

South Australia's Mental Health and Wellbeing Policy [66], provides a vision for the future of mental health care in South Australia, outlining ongoing reform of the mental health care system into the next decade. Mental health reform [66] is underway following the report Stepping Up – A Social Inclusion Action Plan for Mental Health Reform.

The Framework for recovery-oriented rehabilitation in mental health care [67] was developed in 2012, to work towards a recovery-oriented mental health system that supports individuals' unique and personal journeys to wellness. This will be achieved by providing holistic, recovery-oriented, evidence-based rehabilitation services in which service providers work collaboratively and with due regard for the expertise of the individual, their carers and their families to support each person's recovery journey.

A Mental Health Lived Experience Register [68] provides a mechanism for people living with lived experience to provide feedback, observations, ideas and recommendations for improving Mental Health Services in South Australia.

3.2.5 West Australia

The WA Mental Health Commission is reforming West Australia's mental health system. Remit for the WA Commission is wide, with responsibility for strategic policy, planning, purchasing and monitoring of mental health services in Western Australia. In addition, the Commission seeks to raise public awareness of mental wellbeing, promote social inclusion and address the stigma and discrimination affecting people with mental health problems and/or mental illness – all important components of recovery work. It's Strategic Plan *Mental Health 2020* [69]*,* is recovery oriented and underpinned by five key principles:

1. Respect and participation. People with mental health problems and/or mental illness, their families and carers are treated with dignity and respect, and their participation across all aspects of life is acknowledged and encouraged as fundamental to building good mental health and to enriching community life.

2. Engagement. People with mental health problems and/or mental illness, their families and carers are engaged as genuine partners in advising and leading mental health developments at individual, community and service system levels.

3. Diversity. The unique needs and circumstances of people from diverse backgrounds are acknowledged, including people from Aboriginal or from culturally and linguistically diverse (CaLD) backgrounds, people with disability and people of diverse sexual and gender orientation, and responsive approaches developed to meet their needs.

4. Quality of life. By developing personal resilience and optimism, maintaining meaningful relationships, having access to housing and employment, opportunities to contribute and engage within the community and access to high quality mental health services when needed, individuals can build a good and satisfying life despite experiencing mental health problems and/or mental illness.

5. Quality and best practice. Mental health programs and services are statewide, based on contemporary best practice, easily accessed and delivered in a timely and collaborative way.

3.2.6.Tasmania

The Tasmanian Mental Health Strategic Plan 2006-11[70] has, as a central component, a model of care for mental health that is centred on consumers, promotes their recovery, and is provided equitably and efficiently.

To ensure this focus continues, the 2013 Budget submission [71] from the Mental Health Council of Tasmania urges further funding support to promote social inclusion, enable recovery oriented services and the introduction of peer workers, amongst other things.

3.2.7 ACT

The Mental Health Services Plan [72] establishes a vision for a mental health system in the ACT.

In the ACT in 2020 the mental health system will be consumer oriented and driven and focus on recovery and rehabilitation. Consumers and carers will have seamless access to a coordinated and interconnected network of services provided by the consumer, community, public and private sectors and designed to meet the mental health and psychosocial needs for individual health and wellbeing.

3.2.8 NT

The Mental Health Program's Policy and Program [73] Management team is a small team based in Darwin. It works in partnership with health services, clinicians, consumers and their carers to develop mental health services that can provide the best outcomes for Territorians and also has a primary responsibility for implementing, monitoring and reporting progress on all National Mental Health Strategy initiatives such as PHaMs in addition to substantial local responsibilities.

4. Current approaches of care – nationally and internationally

A growing number of approaches/models of care have been developed over the years. While there are variations, they are all based on a common understanding of recovery and recovery-oriented practice. Some of these have had rigorous evaluation, others very little, although there is increasing recognition that it is essential to demonstrate the benefits of these services for the people who use them. Very few have consumer led or collaborative evaluation studies.

4.1 Peer led and self-help approaches

The most popular peer led approaches, developed specifically by and for people with lived experience of mental ill-health, include the following:

4.1.1 Wellness Recovery Action Plan

Wellness Recovery Action Plan [74] (WRAP) is a self-management and recovery system designed to maintain wellness, decrease symptoms, increase personal responsibility and improve quality of life. Developed in the US by Mary Ellen Copeland, WRAP teaches people 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. Typically WRAP is a group program of 2 hourly sessions over 8 weeks, led by 2 co-facilitators. There have been at least six evaluations of WRAP in the United States, as well as one in New Zealand and one in Scotland and it is on SAMHSA's national registry of evidence-based programs and practices. it is used widely around the world in a range of settings.

4.1.2 Intentional Peer Support (IPS)

Intentional Peer Support [75] (IPS) was developed by Shery Mead and is a model of peer support, that is trauma informed and deeply respectful of lived experience. IPS is a way of thinking about and intentionally inviting powerfully transformative relationships among peers. Participants learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other as we try new things. Intentional Peer Support is widely taught and adapted for use in Australia. IPS is supported largely by practice-based evidence, many of the key elements in IPS are incredibly difficult to measure - things like real human connection, the expansion of people's personal worldviews, deeply respectful and honest conflict resolution, and people becoming "unstuck."

Note: WRAP and Peer Support are often used together. Peer Support is about having relationships with others in new and different ways that promote growth, recovery and wellness. WRAP is about living in new and different ways that promote growth, recovery and wellness. By combining the two, the skills and strategies discovered in peer support can become part of WRAP and the skills and strategies discovered as people learn about and use WRAP assist in peer Support.

4.1.3 Peer Warm Lines

A warmline, such as the Metro Boston Recovery Learning Community Peer Warm Line [76], is a compassionate peer-run telephone support and referral line staffed by people in recovery themselves.

Phone surveys [77] conducted with 480 callers over 4 years indicate that peer-run warm lines can fill an important void in the lives of individuals living with mental illnesses. Researchers found that although warm lines at any time of day are helpful, keeping warm lines running after 5pm and throughout the night provides support services not typically available after office hours and can assist with loneliness, symptom management and the process of recovery. Warm lines staffed with appropriately trained, clinically supervised, compensated peer specialists can help round out mental health services in rural and urban communities.

4.1.4 PeerZone

Developed by Mary O'Hagan, Sara McCook Weir and other peers in New Zealand, PeerZone [78] is a series of 3 hour peer led workshops in mental health and addiction where people explore recovery and whole of life wellbeing. PeerZone works on three levels for participants: invites them to rebuild a more positive story of their lives, offers tools for whole of life wellbeing and creates a community of mutual support. There are 19 workshops within five themes: Understanding ourselves, Empowering ourselves, Working on our wellbeing, Connecting to the world, Exploring our unique identities. The evidence underlying Peer Zone is clearly articulated on the site itself and there are plans for a full evaluation.

4.1.5 Support groups

Support groups such as GROW and Hearing Voices groups are now well established.

GROW [79] began in Australia in 1957 and now has peer groups throughout Australia and overseas (the USA, Ireland and New Zealand). Grow's program of personal growth, group method and sharing, caring community has been developed from the findings and experience of people with a mental illness in the course of their recovery and rebuilding their lives. Grow is a community of persons working towards mental health through mutual help and a 12 Step Program of recovery. While the 12 step approach is not for everyone, there is some evidence [80] of GROW's effectiveness.

Hearing Voices groups [81] are based firmly on an ethos of self-help, mutual respect and empathy. They provide a safe space for people to share their experiences and support one another. They are peer support groups, involving social support and belonging, not therapy or treatment. However, groups do offer an opportunity for people to accept and live with their experiences in a way that helps them regain some power over their lives. Currently there are groups in the UK, USA, Greece, Palestine, Japan, Australia and Denmark. Hearing Voices Network Australia was first set up in WA in 2005. There are now established networks in WA [82], Victoria [83] and in NSW [84] and there are plans for networks in Queensland and Tasmania. No rigorous evaluation has been identified but a preliminary British study [85] found statistically significant improvements in participants' ability to live with and even control their voices, as well as collecting evidence of the qualitative benefits of knowing that others are also struggling with what can be a very isolating and alienating phenomenon. Hospital bed use decreased and there were increases in coping strategies, self-esteem and empowerment.

4.2 Approaches with peers as co-leaders

4.2.1 Collaborative Recovery Model (CRM)

The CRM [86], developed in Australia by the University of Woolongong, incorporates practices from a range of sources that have been shown to assist people living within enduring mental illness.

Advantages of the model are that generic skills are gained that can be used flexibly, there is an emphasis on autonomy, hope, and individual experience central to recovery and that a system of measurement is incorporated. The CRM model, which has been picked up by non-government organisations in Australia, is also relevant to the broader "system of recovery" eg carers, self-help and whole organisations in addition to mental health workers. A Training Program, based on the CRM model, is available.

A number of studies have been conducted on various component of the model. In consumers' evaluation [87] of this model, clear avenues for improvement for the CRM, both specific to the model and broadly applicable to recovery-oriented service provision, were identified. Findings suggest consumers want to be more engaged and empowered in the use of the CRM from the outset. In late 2009 the University of Wollongong (UOW), in partnership with five non-government mental health agencies, were successful in receiving an ARC (Australian Research Council) Linkage Grant to look into the factors that impact on the transfer of training into practice following the involvement of staff in the Collaborative Recovery Training Program [88].

4.2.2 Recovery Colleges/Recovery Education/Recovery Learning Centres

Recovery Innovations [89], based in Arizona, (and now operating in several other states and in NZ), set up its Recovery Education Center [90] in 2000, with a deliberate strategy to convert traditional treatment interventions to educational opportunities. Providing education to people who have had psychiatric experiences, their families, and the mental health provider community and licensed as a post secondary vocational institution by the State of Arizona, the Recovery Education Center offers community college credit through a partnership with South Mountain Community College. Both a certificate and an Associate of Arts degree in Mental Health Recovery are available.

Recovery Learning Centres such as those in the Metro Boston Recovery Learning Community [91], offer peer-to-peer services for people in recovery from mental health and/or substance abuse issues, through the utilization of peer support, advocacy, referral, education, career coaching and job readiness in a trauma-sensitive and person-centered manner. The needs and desires of community members are listened to and specific groups, classes, and activities are then provided based on their input.

Recovery Colleges [92] are emerging in the UK using education as a model for recovery. One of the key features is that there is co-production between people with personal and professional experience of mental health problems at every stage.

With a strong evidence base [92] for their development, they deliver comprehensive, education and training programs within mental health services. They run like any other college, providing education as a route to Recovery, not as a form of therapy. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals. Their services are offered to service users, professionals and families alike, with people choosing the courses they would like to attend from a prospectus. Recovery Colleges offer peer support from both peer trainers and fellow students.

The courses are designed to put people back in control of their life, helping each person to identify goals and ambitions whilst giving the confidence, skills and support to access opportunities. There are four established Recovery Colleges in England, with several more due to open soon. The model is also being picked up in Australia – see later.

4.2.3 Shared decision-making

Shared decision-making [93] (SDM) is an approach to treatment decision-making that involves collaboration between a clinician and a client. Multiple health professionals and/or caregivers may also be involved. SDM promotes the selection of a treatment choice that is based on both evidence and client preferences. The stages of SDM include:

- two-way exchange of information between clinician and client (the clinician communicates information about the suitable treatment options and the potential risks and benefits of these options, while the client communicates information about their values and preferences about these treatment options)
- deliberation on this information (the clinician and client discuss these possible outcomes and values and preferences)
- selection of an option that is consistent with the values and preferences of the client. It is also important to make a time to review this decision

New developments utilising computer-based programs are demonstrating the variety of ways in which SDM interventions occur and hold promise particularly for young people. SDM is showing promise as being valuable around medication use [94]. Australasian Psychiatry in press.

4.2.4 The Strengths model

The Strengths Model [100] is a model of case management with people suffering from severe and persistent mental illness. It has been around for many decades and is now seen as an integral part of good clinical practice. There are 6 principles**:**

1. focus on individual strengths rather than pathology
2. case manager client relationship is primary and essential
3. interventions are based on principles of client self determination
4. assertive outreach is the preferred mode of intervention
5. long term psychiatric patients can continue to learn, grow, change and can be assisted to do so
6. resource acquisition goes beyond traditional mental health services and actively mobilizes resources of the entire community

4.2.5 Tidal model

The Tidal Model [96] of Recovery and Reclamation was developed *jointly* by mental health nurses and consumers. Developed and widely used in the UK, it is the first model to focus beginning the recovery journey when the person is at their lowest ebb and is a model of mental health nursing used as the basis for interdisciplinary mental health care. The Tidal Model is an approach to recovery, not a rigid system. Each of the many Tidal projects across the world is exploring different ways that people can discover their mental health, in a personally, socially and culturally meaningful way.

While the model developers believe that it is difficult for the model to be shown to work, the report from one site in Birmingham [97] showed that structuring nursing care in different ways, for example by working collaboratively with service users from assessment through to care planning and evaluation, and making time to engage with and talk to patients, can improve service users' experiences of their care and improve nurses' perceptions of their contribution to a person's care. There was a significant reduction in untoward incidents, a shorter length of stay and a reduction in complaints from service users about nursing care and staff attitude. Some service users found that their care was much more focused than previously and that staff had more time to talk to them. There has been little activity on the Tidal Model website for the last few years.

4.3 Measuring Recovery

Who decides when someone is recovered? To be true to it's underlying philosophy, when measuring the effectiveness of recovery approaches, it is important to involve consumers and carers meaningfully in the design and implementation of outcome measures. In order to satisfy funding requirements and accountability, it is also an important consideration to include external/objective measures and internal/subjective ones.

With the majority of outcome measures in Australian mental health services focussing on symptoms and functioning, several stakeholders [98] have argued for the necessity of a recovery outcome measure as described by consumers. However, many consumers argue that recovery is a personal process, and should not be reduced to an outcome measure.

Instruments [99] are available designed to measure the recovery orientation of services but further development and testing of these is needed for the Australian context. The following are some of the 'tools' developed with consumers that are currently or soon to be available.

4.3.1 Recovery Star [100] is a UK tool for people using services to enable them to measure their own recovery progress, with the help of mental health workers or others. The 'star' contains ten areas covering the main aspects of people's lives, including living skills, relationships, work and identity and self-esteem. Service users set their personal goals within each area and measure over time how far they are progressing towards these goals. This can help them identify their goals and what support they need to reach them, and ensure they are making progress, however gradual, which itself can encourage hope. This tool includes physical health as a measure.

4.3.2 ROSSAT [101] **The Recovery Oriented Service Self-Assessment Toolkit** developed by the NSW Consumer Advisory Group and the Mental Health Coordinating Council (MHCC) assists organisations and staff to assess their level of recovery oriented service provision; reflect on both individual and organisational practice in relation to recovery oriented service provision and identify areas requiring improved practice in delivering recovery-oriented services. ROSSAT has been mapped to the 2010 National Standards for Mental Health Services.

The six Key Indicator Areas considered by the ROSSAT are:
- Relationships
- Respectful practice
- Consumer self-directed focus
- Belief in consumers recovery
- Obtaining & sharing knowledge and information
- Participation and social inclusion.

4.3.3 The MH ECO Toolkit [102] developed in Victoria, will be available soon. Mental Health Experience Co-Design (MH ECO) is an innovative method of gathering information about the lived experiences of consumers and carers who have received a service from mental health services. MH ECO also gathers information about the experiences of mental health professionals who provide mental health services. MH ECO then brings together consumers, carers and service providers in partnerships to analyse and use their experiences to co-design service quality improvements.

4.3.4 Developing Recovery Enhancing Environments Measure [103] (DREEM) is an outcome measure and research tool to see how 'recovery-oriented' a service is. It is a self-report instrument that gathers information about mental health recovery from people who using mental health services. The DREEM asks people where they are in their process of mental health recovery and what markers of recovery they are currently experiencing.

4.3.5 COAT Consulting [104] - Consumer Auditing Tool (CoAT) Consulting is a partnership formed specifically to audit the New National Mental Health Standards and to develop other activities identified as a result of using the CoAT. Workshops are held, where key stakeholders of public Mental Health Services, consumers, carers and service providers, work in partnership to evaluate their services and to identify ways to continue to improve public Mental Health Services.

5. Identification of approaches/sites/services/agencies in Australia that represent good practice

There are a multitude of Recovery-oriented services and programs around Australia. The following is a sample only. Some are programs within larger organisations and some are stand-alone. Some are consumer led and some are partnerships. All have an evidence base for good practice. Many of these are winners of awards from the Mental Health Services (TheMHS) conference of Australia and New Zealand. Visit TheMHS [105] for a full listing of past winners.

5.1 Peer run services – operated for and by consumers or carers

5.1.1 Brook RED Qld

The Brook RED Centre [106] is a Peer Operated Service providing a range of activities and supports for people who identify as having or having had a personal experience of a mental health concern or illness or has used mental health services for their own need. Based on the principles of Shery Mead's Intentional Peer Support Approach, the Brook RED Centre is one of 3 Consumer Operated Services funded by both the Queensland Department of Communities Mental Health Branch and The Department of Health and Ageing. Others are at the Sunshine Coast and in Hervey Bay.

The Brook RED Centre currently operates from two community-based centres in Brisbane South and Brisbane East and programs include discussion groups, arts programs and internet access.

5.1.2 Consumer Activity Network (CAN)

CAN [107] is a mental health consumer run organisation based in Sydney providing local & national peer support services and recovery activities for consumers by consumers. CAN receives funding from the Australian Government Department of Health and Ageing. Phone Connections is a peer support line for mental health consumers, provided by mental health consumers, based on warm lines in the USA and NZ. Phone Connections operates 4 evenings per week.
Hospital to Home provides practical assistance and peer support to consumers within the first 6 weeks of discharge from 2 Sydney metropolitan psychiatric inpatient units. Evaluation of these programs found that these services provide a low cost yet valuable support mechanism for consumers at vulnerable times in their recovery journey.

5.1.3 Consumer Research and Evaluation Unit (CREU)

The CREU [108] represents a unique model sitting within the Victorian Mental Illness Awareness Council, a consumer created and led organisation. The Unit has a team of skilled personnel with experience and skills in research and evaluation techniques, however, the basis for their work and the creation and growth of the Unit is around their lived experience. The Unit advocates for consumer research as a new and emerging field where research is initiated, designed, controlled and conducted by consumers and whereby new methods and approaches are developed from a consumer perspective. This rights-based, grass roots philosophy is posed as an alternative to academic research and seeks to add a different and complementary approach to the mental health sector.

5.1.4 Our Consumer Place

Our Consumer Place [109] is a comprehensive resource centre run entirely by people diagnosed with "mental illness" ("consumers"), providing information, training, support and advice to consumer-run groups and projects (or more specifically, "Consumer Developed Initiatives" (CDIs)). We also support what we call "consumer perspective," recognising that the lived

experience of "mental illness" provides a crucial source of insight that is of value and must be respected. We believe that we are part of an important cultural shift, towards valuing and respecting the lived experience of "mental illness." Our Consumer Place delivers training in Intentional Peer Support (IPS), developed by Shery Mead, produces resources and has a monthly newsletter with news, essays, interviews and analysis.

5.1.5 The Maine Connection

With the decreasing focus on informal 'Drop In' type programs so there has been an increase in the number of small consumer run support groups, which operate on recovery principles. One such program is The Maine Connection [110] in rural Victoria where people with long-standing mental health issues come together.

5.1.6 The Well Ways and MI Recovery programs

The Well Ways MI Recovery [111] education program, which was developed by the Mental Illness Fellowship of Victoria (MIFV), is led by trained peer facilitators. Drawing on Shery Mead's work this series of group workshops, provides information, support and skills to manage mental illness, helping participants re-discover and start to achieve their hopes and dreams. The program includes 10 weekly 3-hour sessions

The family peer education program, Well Ways, (also developed by MIFV), provides information and support to carers and families of people with mental illness. This family-to-family model harnesses the knowledge and first-hand experience of educators who have cared for loved ones with mental illness. Well Ways comes in three versions to meet different needs: the comprehensive Building a Future, Duo (specifically for carers of people with a dual diagnosis of mental illness with alcohol or drug problems) and Snapshot (a shorter option for families in rural and remote areas). Evaluation has shown the program's effectiveness in reducing negative care-giving consequences for families of people with a mental illness. Well Ways programs are run by member organisations of Mental Illness Fellowship Australia around Australia.

The Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) has funded the delivery of Well Ways Building a Future and Well Ways MI Recovery peer education programs to ensure consumers and carers feel empowered to make decisions within the National Disability Insurance Scheme (NDIS). This National Program, implemented by MIFV, has trained 62 carer peer workers and 62 consumer peer workers as accredited *Well Ways* peer facilitators. *MI Recovery* is now running around the country.

Stigma reduction – Case study

Breaking Free is a longstanding Toowoomba concert program held during Mental Health Week, on Breaking Free Day, to raise community awareness and reduce stigma and discrimination.

It was developed to make sure people in the local community of Toowoomba understand that people with mental illness are citizens - members of the community like everybody else and should not be isolated or labelled or unable to feel welcome and safe in the community. The Breaking Free concert pulls people together in a fun activity to send this message.

5.2 NGOs with strong recovery focus

All the major NGOs around Australia have a strong commitment to recovery. Many run PHaMs programs and are involved with Medicare Locals for the first roll out of Partners in Recovery. A wide variety of programs are offered, a sample of these initiatives and organisations are:

5.2.1 Carers Offering Peers early Support (COPES)

ARAFEMI in partnership with Eastern Health provides the Eastern COPES program [112] to provide additional support to carers and families across the inner Eastern region of Melbourne. The COPES workers provide support, information and referrals. They listen and help explore different pathways to recovery. This service is particularly helpful for people who find it difficult to express themselves over the phone and prefer to talk face to face with someone about what is going on. COPES workers must have experience as an unpaid carer/family member for an adult with mental illness who has been treated in the public mental health system.

A 2009 evaluation [113] of COPES revealed 15 out of 16 carers surveyed found it to be beneficial; with 100 per cent saying they would recommend COPES to others in a similar situation.

5.2.2 Mind Australia

Mind Australia [114] is a leading provider of community mental health services, supporting people's mental health recovery. Underpinning Mind's work is a belief that it is possible for everyone to have a full and meaningful life, including people with severe and persistent mental health issues. Mind has recently undergone a restructure that has included the appointment of Anthony Stratford as Senior Advisor Recovery. This appointment reflects the importance of including people with a lived experience of mental ill health and recovery in senior executive roles, and the importance of embedding a culture of recovery across the organisation.

Mind is currently implementing a pilot Recovery College, based on the models from the UK. Untilising the principles of co-production, the Recovery College will provide an educational platform to support people's recovery. Learners will undertake courses, and be supported through the development of individual learning plans. The pilot is in early stages of development, and has not yet been formally launched.

5.2.3 Neami National

Consumer involvement and participation is an integral part of Neami [115], a non-government mental health organisation providing support services within a recovery framework to people with a serious mental illness in most States of Australia. Consumers have input into all levels of the organisation and are involved in the development, implementation, and evaluation of the services provided. Several consumers are Board Directors.

Neami staff use the Collaborative Recovery Model (CRM) to assist consumers to build their confidence and skills to develop a sense of meaning and purpose in their life. The peer facilitated *Flourish* program builds on the principles of the CRM by focusing on individual strengths and values in relation to personal goals. The principle of *Flourish* is that you decide on your own recovery goals. The aim of the program is to motivate and equip people with the tools necessary to achieve positive changes within their lives. Flourish is a 12 week program with fortnightly group meetings and personal follow up between meetings.

In 2013, Neami will begin the roll out of *Launching Pad*, a skills development leadership program to equip interested consumers of the service with the necessary skills and supports to become Lived Experience Partners, providing policy and other advice within the organisation and the broader community.

5.2.4 Peer Work Project

Baptist Care (SA) and the Mental Illness Fellowship South Australia MIFSA set up the Peer Work Project [116] in 2005 to support peer workers and the organisations that employ peer workers. The project is designed around a recovery approach, and although non-accredited, it offers a basic introduction to the nature of the Peer Work role and provides a solid foundation that organisational or other specialist training can build on (eg. Certificate IV in Community Services, Mental Health, non-clinical). The focus of the project is to support organisations in the recruitment, organisational preparation, training and support of peer workers, and to support peer workers by offering training and assistance in finding suitable peer work and workplace support.

5.2.5 Richmond PRA

RichmondPRA [117] helps people get back on track and reconnect with the community to live a contributing life. Working in local communities in NSW and South East Queensland their services are designed to support people in the way that suits best, whether through help finding a place to live, a job that's fair and rewarding, or more structured health services to assist day-to-day living.

Mental health recovery is the focus, working to build on participants' strengths and offer choice and diversity and there is strong commitment to employment of people with lived experience. Richmond PRA also provides advice to family members and friends who may need access to information about supporting a loved one with a mental illness or need support for themselves. Close to thirty per cent of staff identify as someone with a lived experience of mental illness and that number is increasing. Richmond PRA's Recovery Action Plan guides the future development of the organisation including the Board, people using their services, management and staff to enact recovery values in all internal and external activities.

5.2.6 The Centre of Excellence in Peer Support

The Centre of Excellence in Peer Support [118] provides a centralised specialist clearinghouse and online resource centre for mental health peer support. Established in Victoria by seven statewide Mutual Support and Self Help organisations and launched in June 2011, this project was set up in response to the growing interest in and recognition of peer support work for both consumers and families/carers, it supports the peer support sector by providing linkage, service mapping and information-sharing.

Peer Recovery coaches – Case study

SANE Australia and Neami National have commenced a three year demonstration project to improve the physical health outcomes of people living with a mental illness using a Peer Support Health Coach model. The program is being delivered and evaluated through Neami National, a mental health non-government organisation. The project will also investigate the effectiveness of 'peer educators' as 'coaches' for improved self-management of chronic conditions such as diabetes and smoking cessation.

Current Neami Peer Support Workers attend "Peer Health Coach" training delivered by SANE to enable them to work one on one or in small groups with consumers who have indicated they would like to work on an aspect of their physical health as part of their recovery. The Peer Health Coaches add value to the project through their lived experience and role modelling.

Currently there is no existing peer coaching workforce concentrating on improving consumers' health behaviour, health literacy and promoting self management of physical illnesses. An outcome of this project is to develop a best practice model to be promoted and shared with the mental health sector.

5.3 State Mental Health services

A growing number of clinical services are actively adopting a recovery approach in their services, utilizing several of the models previous discussed and involving consumer and carer peer workers. However, while there are impressive areas of consumer and carer engagement with both clinical and community programs at large services such as St Vincent's Mental Health services in both Sydney and Melbourne, the process of cultural change can take time.

Interesting approaches in services include:

5.3.1 Lismore Lived Experience project (LEP)

The LEP [119] developed, implemented and evaluated a training, coordination and support package to facilitate the transition of people with a lived experience of mental illness and recovery into education, work experience and employment as peer workers in mental health and community services sector organisations throughout the North Coast of NSW. It focused on showing that people with mental health issues can not only make a full recovery, but can then use their experiences to help others with their journey to become gainfully employed and reduce the burden on an under-resourced health system.

Funded by the Australian Government Department of Education, Employment and Workplace Relations under the Innovation fund, the pilot project was delivered by ACE North Coast Community Colleges at their Tweed and Lismore campuses. Peer support Workers and Consumer Representatives were employed to be on the LEP steering committee and peer educators were involved with training.

Thirty participants successfully completed prevocational training and engaged in study and work experience placements designed to meet the requirement of a Certificate IV in Community Services Work. Twentyfive participants graduated with a Certificate IV in Community Services and engaged with local employment partners in mental health and community services via mentoring, work experience placements and paid employment. An education and training package was developed, presented and distributed to employment partners to help them employ peer workers successfully.

Following the training 19 positions of paid employment for project participants were identified in 18 months (includes both the initial LEP pilot and the 6-month Making the Lived Experience Count Project). Other successful outcomes were that 3 additional participants completed a Diploma in Community Services (Mental Health) and 4 commenced further tertiary education upon completing the LEP.

5.3.2 Barwon Health Mental Health, Drug and Alcohol Services

In Barwon Health MHDAS "engaging leadership" [47] was used as a tool for culture change by developing a highly productive workforce who would be more open and innovative when considering a recovery approach. The executive team realised this path would lead to better outcomes through shared responsibility, achieved via a coaching relationship rather than the historical paternalistic style of mental health service delivery.

In creating a recovery-oriented workforce, a consultant with a lived experience of mental illness was hired early on to work jointly with psychiatrists, leaders and clinicians to explore the concept of recovery. Each mental health team in the service identified a "champion" to become the recovery mentor who organised an ongoing reflective practice session with the team to explore the concepts and reach their own conclusions about how to progress recovery.

In parallel, the executive team held their own reflective practice sessions to reflect on their leadership of the service, and worked with Real World Group to create a vision and strategy for creating an engaging leadership culture.

Two years on, the service reaps the benefits of open enthusiasm and debate around recovery, with each team working actively on a project to improve the way care is delivered. Assessed employee engagement levels have significantly increased year on year. The highlight has been the demonstration of how sharing responsibility with staff has enabled them to be motivated, creative and innovative in their thinking around recovery.

5.4 Research Initiatives

5.4.1 Mental Illness Research Fund Victoria [120] is a $10 million Victorian Government initiative aimed at supporting multidisciplinary and cross-sector collaborative research that has the potential to be translated into tangible improvements for Victorians with mental illness and their carers. The first beneficiaries were recently announced:

a. Use of online technology to promote self-management and recovery in people with psychosis ($1,966,610) led by Professor Mike Kyrios at Swinburne University.

Research partners are Swinburne University, the Mental Illness Fellowship of Victoria, Mind Australia, Alfred Health, Melbourne Health and St Vincent's Mental Health.

This project will explore how online, multimedia based therapy can be better developed and more routinely used by mental health workers, patients and carers as a core part of treatment. The research will focus strongly on how this can help people with severe mental illness develop skills to effectively manage their own illness. It will rigorously test the benefits of this approach in achieving improved health and social outcomes.

b. The HORYZONS project: Moderated Online Social Therapy for Maintenance of Treatment Effects from Specialised First Episode Psychosis ($1,792,727)**,** led by Dr Mario Alvarez-Jimenez, a Senior Research Fellow at the Orygen Youth Health Research Centre.

Research partners are Orygen Youth Health Research Centre, the Australian Catholic University, the University of Melbourne and Deakin University.

The researchers have identified a clear gap in availability of easily accessible and engaging ways to help young people with psychosis avoid relapse, maintain engagement with mental health services and continue to recover after initial treatment. This study will test the impact of an online program called HORYZONS in long-term recovery for young people diagnosed early in the course of a psychotic illness. If effective, HORYZONS will provide a world-first resource for this purpose, combining social networking, peer support, online therapy and easy access to health professionals.

c. Getting to the CORE: Testing a co-design technique to optimise psychosocial recovery outcomes for people affected by mental illness, **(**$1,777,332)**,** led by Dr Victoria Palmer at the University of Melbourne.

Research partners: University of Melbourne, Victorian Mental Illness Awareness Council, Victorian Mental Health Carers Network and eight selected community health centres throughout Victoria.

This research will investigate the value of actively involving people affected by mental illness in the design of treatment and care, and examine how this approach can best improve mental health services. The project will build on the widely recognised work of Victoria's mental health consumers and carers in fostering partnership with clinicians to improve their service experiences and quality. The project will take this work further by testing if the approach will improve the recovery outcomes for consumers in eight community health centres across Victoria.

d. Working together with shared values towards recovery-oriented practice – Principles Unite Local Services Assisting Recovery – the PULSAR project ($2,331,460)**,** led by Professor Graham Meadows at Monash University

Research partners: Monash University, Mind Australia, Eastern Region Mental Health Association, Southern Health, University of Melbourne, La Trobe University, Victoria University and University of London.

This project will test a practical approach to address the vital issue of how different types of services within a defined geographical area can be refocused to support recovery for people with mental illness. It is expected to shed light on how clinical mental health, primary care and community support services can collaborate effectively and support people with mental illness achieve their personal recovery goals. The research will adapt and test the usefulness of a set of training materials and organisational change techniques first used in the UK, with particular focus on how they can be suited to the Victorian context.

e. Developing an Australian-first recovery model for parents in Victorian mental health and family services, ($1,855,891)**,** led by Associate Professor Darryl Maybery at Monash University.

Research partners: Monash University, SANE Australia, Family Life, Neami, Bouverie Centre, Parenting Research Centre, Raising Children Network, beyondblue, Eastern Health, Northern Health and University of South Australia.

The key question to be addressed by this project is how we can improve longer-term recovery of people with severe mental illness by addressing their parenting role as a core part of their treatment. To answer this, the researchers will trial specific innovative interventions that engage families and children within specialist mental health services. An Australian-first, this approach is expected to deliver significant mental health and wellbeing benefits to both parents and children.

5.4 2 Australian Research Council Linkage [121] project grants include:

Options for supported decision-making to enhance the recovery of people with severe mental health problems led by Monash University

Partner Organisations: Victorian Department of Health, Mind Australia, Mental Illness Fellowship Victoria, Neami, Victorian Mental Illness Council, Victorian Mental Health Carers Network

This project will examine the views of people with severe mental health problems, carers and mental health practitioners concerning appropriate supports for making treatment decisions. The project will produce an internet- based resource and training materials that explain supported decision-making and how it can contribute to the process of recovery.

6. Gaps in knowledge

There is much we do not know about how best to implement recovery-oriented approaches. Some of the major gaps identified are as follows.

6.1 Special populations

Mental health practitioners recognise that biological, psychological, environmental, economic, social and political factors all impact on health and wellbeing at a personal, local and global level. It follows then that recovery involves numerous processes that occur within a web of relations, including the individual, family and community, and is contextualised by culture, privilege and or oppression, history and the social determinants of health. Recovery also occurs within the context of gender, age and developmental stages. Recovery approaches by applying an understanding of developmental needs, benefit people at all ages across the lifespan.

Recovery approaches are alert to the impacts on health and wellbeing, both positive and averse, of diversity – whether they are socially, culturally, and/or language based.
National Mental Health Recovery Framework [1], Supporting recovery in a diverse Australia

The National Framework outlines how the person first, holistic and individualised approach of recovery-oriented practice means that the needs of diverse groups can be accommodated - although not without challenges. While services for young people are already embracing recovery oriented practice, the document addresses concerns and outlines how service settings such as acute, aged care and the Forensic system, can adopt a recovery approach.

There is a great need for action research to identify the training, development and other needs to support recovery for people with mental health problems from these diverse groups as well as people who have dual diagnoses such as alcohol and drug problems or co-existing physical health problems. Two groups in particular are highlighted:

6.1.1 Aboriginal and Torres Strait Islander Peoples, Families and Communities

More research is needed on recovery approaches for Aboriginal and Torres Strait Islander Peoples. How we can help improve recovery in their communities and, importantly, what we can learn from them. Recovery approaches are synergistic with the idea of social and emotional wellbeing and there may be much to learn for mainstream practice from indigenous community practices. The Supplementary Paper [122] to A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention Prepared by Chris Holland, with Pat Dudgeon and Helen Milroy for the National Mental Health Commission March 2013 outlines these issues clearly.

6.1.2 People from Culturally and linguistically diverse backgrounds (CALD)

For example some early work has been done using an Assertive Communication Skills program, which has been adapted for use with Chinese Australians [123] in Sydney. Culturally-appropriate programs in *Assertive Communication Training*, perceived by participants as carrying no stigma, were effective in reducing stress levels and improving acculturation in a sample of low-acculturated Chinese-Australians. The program was well received suggesting that further culturally appropriate programs are needed to improve the mental health and well-being of CALD or ethnic minority groups.

6.2 Carers/friends/support people

The Identifying the carer [124] project, in its final report for the Commonwealth Department of Health and Ageing, commented that a true recovery approach is fundamentally about strengthening hope and optimism not only for individuals with mental illness, but also for their carers and for the service providers who work with them.

While plans and policy documents include carers in statements about recovery (usually as an appendage to consumers), the concept of recovery is different for carers and there are fewer carer peer workers than would be expected.

Consumers and carers often have different perspectives on their interaction with the mental health service system, experience of recovery and requirements for information and support. Both groups, however, can contribute to and benefit from peer work. The National Mental Health Consumer and Carer Forum notes that it is not appropriate to expect carer workers to be able to provide expert advice or assistance for consumers, or for consumer workers to be able to provide expert advice or assistance for carers. Consumer peer workers can and do support consumers, and carer peer workers can similarly assist carers and families. The new Cert 4 in peer work acknowledges these differences and has different consumer and carer streams and the resources in development will also be tailored.

There is agreement [31] that carers have a significant and important role in supporting and enabling recovery for their relative and/or friend. However more research is needed on ways in which carers themselves can be supported for their own recovery from the traumatic circumstances they are or have experienced, as well as to enhance recovery for the person they care about. The systemic changes needed for this to happen also need investigation.

6.3 The Private mental health sector

There is a large gap in knowledge about how the Private mental health sector can be engaged in adopting a systemic recovery approach, particularly in peer support. Also, while there are individual practitioners who already practice recovery approaches, we know little about effective strategies to enhance communication between the 3 sectors – public, private, NGO – which is an important component of recovery. Close monitoring of the Partners in Recovery program and of the launch sites for Disability Care Australia is important to help learn more.

The Private Mental Health Consumer Carer Network (Australia) reports (personal communication), that there are few consumer consultant positions in the private sector and there are no peer worker roles. Their Policy Document 6: [125] *Consumer and Carer Participation within Private Mental Health Services* says that to achieve truly meaningful consumer and carer participation, all organisations involved in the funding and delivery of treatment and care in the private mental health sector should:

- formulate and adopt a comprehensive definition of consumer and carer participation for their organisations
- engage appropriately qualified consumers and carers within funder and provider organisations as equal members of the service staff
- implement appropriate in–service mental health education, that includes consumers and their carers as educators.

Interestingly, the Network also reports more carer consultant positions in the private hospital sector.

More research is needed to establish ways in which people being treated for mental illness in the private sector can benefit from a recovery approach and the involvement of peer workers.

6.4 Primary care

The role of primary care – general practitioners - is unexplored in the recovery literature, although there is acknowledgement of the need for services and programs to build partnerships with general practice. While many people receive mental health care exclusively from GPs and the concept of recovery sits well in primary care settings, little activity has been identified about the needs of GPs and ways in which they can be supported to be actively and meaningfully involved.

6.5 Social/Internet-based media

Technology is increasingly being harnessed to help people in mental health recovery but often without an evidence-base or sound evaluation. There is need to research how technology can best be harnessed to promote recovery and minimise potential negative impacts.

There are attempts to provide people with reliable information and advice. For example, the Mindhealth*connect* website [126], launched in July 2012 as part of the Australian Government's National E-Mental Health Strategy, is a trusted gateway to many reputable websites providing mental health information, support and online help. It also has a resource library.

Visitors to the ANU's e-hub's [127] suite of online self-help services can get links to online help, and online communities such as Headspace Facebook page [128] and the National Coalition for Mental Health Recovery [129], provide a sense of community, updates on new developments and optimism about recovery. Online forums such as those such by Reach Out! [130] have demonstrated value for young people in early intervention.

There are a growing number of apps [131] – the Apple Store has 700 - for a range of mental health conditions. For example, the Phobic Trust mood diary mobile app [132], enables users to record anxiety and stress levels, mood triggers, sleep and exercise patterns, as well as set clinical appointment and medication alerts. Recovery Record [133] is an app where people with anorexia note such things as what they eat, how they feel, whether they wanted to purge or binge, and these details, and more, are sent automatically to their psychologist. The Talking Anxiety App [134] helps people learn to manage anxiety face-to-face from the experts – people who've 'been there' - and discover techniques that really work and complement medical therapy. Or for young people facing depression, homophobia or bullying, there is The Fifth Army [135], a new app from Headspace.

However, few of the available Apps have been tested to ensure they are effective and safe. As with everyone, for people recovering from mental illness, technology can have negative consequences as well as positive ones and further research on these is needed.

The Positive Impact of Technology on Mental Health **- Healthy Place Mental Health Blog** [136]

We are able to connect with people who struggle with–and recover from–a mental illness.

- We can share our opinion, our experiences, while being "anonymous" AKA I am currently wearing a rather hideous gym shirt, but you cannot see this. Jokes aside, it's important we feel safe sharing personal parts of our lives. The internet can be a great place to do this.

- We have a wealth of information. We can now "research" mental health and, if done correctly, use this information to make positive strides forward.

- The most important thing: We don't need to feel as alone in our battle.

I'm focusing primarily on the internet because it's the most widely used when we are focusing on mental health, but the ability to pick up a phone and call someone is important. If we need to take some time out we can watch television, but like all good things, technology has negatives.

The Negative Impact of Technology on Mental Health

The strange thing is the *positive* attributes detailed above can translate into *negative* experiences.

- While connecting with others online can he helpful, we need to make sure those we interact with *are* positive. We don't need to interact with those who, for example, tell us what medications we should or should not take.

- We can share our opinion and, as I mentioned, maintain anonymity. But the internet does not always protect our privacy and we need to make sure we only provide information we are comfortable sharing.

- The ability to research medication. I hesitate to say that this can be more of a detriment than a positive. For example: If you are prescribed a new medication you might immediately go home and Google it. You might read pages of side-effects. Try not to "research" specific medications online, but do take time to find recovery related websites.

- Technology can impact our sleep-cycle. Instead of reading a book we might watch TV or (and I am guilty of this) play ridiculous games on our iPad or computer.

Yes, technology impacts our mental health but it's like anything else when working to recover from mental illness—find the positives and do your best to ignore the negatives.

7. Special issues and key areas of concern

A number of special issues are raised about recovery approaches and peer support. These can be grouped as follows:

7.1 Peer workforce development

Peer workforce issues include the need to develop peer worker core competencies, standardised education and training, effective support and supervision, career pathways and the achievement of wage equity. These concerns are being addressed in the new *Peer worker project Literature Scan* from Health Workforce Australia.

Establishment of a national association of peer workers with a remit to set standards is also believed to be a necessary development.

7.2 Issues for Services re adoption of recovery approaches

There is no mandate for services to adopt a recovery approach and no Key Performance Indicators are in place around adoption of recovery approaches

Tensions exist for consumers working in an advocacy role, feeling free to advocate against their employing service.

7.3 Recovery approach interpretation

There are tensions between the focus on recovery and continued/growing use of compulsory treatment. Some consumers believe that being subjected to compulsory treatment under the Mental Health Act “hinders” their recovery. For clinicians, the issue of risk continues to be a tension: how to balance crisis treatment with a recovery approach and the important issue of compulsory treatment to protect both the person and the community from harm.

The research literature is not conclusive:

A substantial body of research [137] has established the effectiveness of assisted outpatient treatment (AOT) in improving treatment outcomes for its target population. Specifically, the research demonstrates that AOT reduces the risks of hospitalization, arrest, incarceration, crime, victimization, and violence. AOT also increases treatment adherence and eases the strain placed on family members or other primary caregivers.

However, a recent British study [138] on the use of Community Treatment Orders CTOs found no improvements in outcomes and the authors concluded ‘In well coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty.’

The use of compulsion and involuntary treatment and their place in recovery, is also addressed in the Mental Health Recovery Framework document.

More research and discussion around this issue such as in the recently launched Suicide Prevention and Recovery Guide is critical.

7.4 New developments that will impact on recovery approaches

7.4.1 Activity Based Funding (ABF)
Concerns are being raised [139] about the implementation of ABF in mental health from 1 July 2013 and the potential for risks to a recovery approach as well as benefits. It is thought that the infrastructure to support the application of ABF to mental health is currently weak and requires considerable development. Concern is that as States and territories struggle to meet existing demand for largely hospital-based acute mental health care, there is a risk that valuable ABF-driven Commonwealth growth funds may be used to prop up these systems rather than drive the emergence of new models of community-based care.

7.4.2 NDIS/Disability Care Australia [140]
Major concerns are also being raised in the mental health sector about how people with mental illness will be served by introduction of the NDIS. For example concerns about definitions of disability, the deflection of current funding programs such as Partners in Recovery and PHaMs from Health to Disability Care Australia and whether in some situations the model will in fact work against a recovery approach.

Under the current draft of the NDIS legislation, a person living with mental illness is likely to be eligible for the NDIS if they experience impairment due to a psychiatric condition and the impairment substantially reduces the person's ability to undertake one or more of the following activities: Communication; social interaction; learning; mobility; self-care; self-management; social and economic participation. In addition, to be eligible, a person's need for support would be expected to exist throughout a person's lifetime. However, the draft legislation does recognise that the need for support can vary at different times over the course of a person's life.

The exact wording of the eligibility criteria used in the draft legislation may change during the consultation process, and it is unknown how many people with mental illness will be supported under the NDIS, or what their levels of support will be.

As the launch sites get underway it will be essential to monitor closely the experiences of people with mental illness, to ensure that everyone living with mental illness receives the services and supports needed for their recovery.

In conclusion…..

While there are still gaps in knowledge, and some concerns about how a recovery approach including peer support can best be adopted, it is clear that Recovery is the way forward. Not if the approach is the way forward, but how we can do it most effectively to benefit people living with mental illness.

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Appendix 1.

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