This is the Word version of the survey for the **Discussion Paper of the National Recovery-Oriented Mental Health Practice and Service Delivery Framework Project**. Responses to this survey are needed by the 18th April 2012. Your comments and assistance is greatly appreciated.

The online version of this survey is at……

https://www.surveymonkey.com/s/ROCIMH

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Mental Health in Multicultural Australia (MHiMA) is a collaborative project that aims to provide a national focus on mental health and suicide prevention related issues for immigrants, refugees and their families and offers advice and support to government and non-government providers and service users. This project works across the lifespan, across the spectrum of mental health and has a recovery focus.

We first want to acknowledge the importance of a national recovery-oriented mental health practice framework as an important step to the implementation and the achievement of the goals of the national and states mental health plan.

We are pleased to participate in the national Mental Health recovery framework consultation and our focus will be to look at the framework and see how it addresses the issues of immigrants and refugees experiencing mental illness or disorder and supports their recovery.

1. Are there any other important themes identified in descriptions of recovery provided by people with lived experience that should be included here?

The first point notes that "recovery is a highly personalised experience". Experiences are mediated by cultural, social and historical contexts. It's good to question if there are other themes related to the lived experience of recovering from mental illness that could be included as we know the Australian community is culturally and social diverse and that Australian society is being shaped by many forces including dynamic processes of migration.

Introducing recovery as a journey is important but since we are talking of a national recovery-oriented mental health practice framework, emphasis should be first put on recovery as a ***process***. A process for the individual but in regards to the framework, it is a process between the individual and the practitioner. This process is better qualified as the complex interplay between the characteristics of the individual, the environment and the exchange.[1]

When describing recovery in a cross-cultural context, ***contextual competence*** – the ability and the willingness of a clinician (or service / organisation / system) to be able to place the unique human being they are assisting (i.e. client, patient, consumer) into the various contexts in which that individual exists[2] should be an important theme of the framework.

For immigrants and refugees experiencing mental illness or caring for people with mental disorders, two items often expressed are:

Recovery cannot be fulfilled in an ***environment*** that ***supports racism***, prejudice and stigmatisation;

Social connectedness and ***social inclusion*** is an essential part of recovery.[3]

There are also other themes to consider – some may resonate with those presented here, some may be in conflict, some may enrich the array of what has been presented through this document. That is, consider the centrality of kinship and family ties in many cultures, deference to elders regarding personal decision making, privileging the maintaining harmony within the family over personal ambitions, obligations to engage in acts of charity, facing adversity with acceptance, the importance of engaging in traditional healings and spiritual practices.

We need not only to consider the role relationships with family, friends and peers and practitioners have in fostering hope in relation to recovery on mental illness but also the interplay of broader community beliefs and social structures.

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[1] Queensland Government (2005), *Sharing responsibility for Recovery: creating and sustaining recovery oriented systems of care for mental health*.

[2] Turner G (2006), Moving form Cultural Competency in Multicultural Mental Health to Contextual Competency, *Synergy* (3), Sydney: Multicultural Mental Health Australia.

[3] Ida D.J. (2007), Cultural Competency and Recovery within Diverse Populations, *Psychiatric Rehabilitation Journal*, vol 31, no 1 49-53.

" Many CALD consumers find going around the Recovery Cycle
Rather "Difficult" while others find it "Easy"
Because of language difficulty, no access to services
Transport limitation, isolative nature of mental illness,
Little income."
Evan Bichara, consumer advocate, Victorian Transcultural Psychiatry Unit

2. What is your response to the statement that the concept of recovery can be viewed as an overarching philosophy to guide practice and service delivery?

Considering recovery as an overarching philosophy to guide practice and recovery is a first step to a change of paradigm as put forward by Sade (2009)[4]. It is a very useful description of an improved way of conceptualising how service providers can engage in more effective conversations with service users. It is also becoming a useful description of approaches to providing treatment, therapy and care that consciously and systematically work with consumers, families and carers to ensure that they receive services that sensitively respond to their major concerns.

However all discourses on recovery need to be self-critical. For this reason talk of a "philosophy" is problematic – i.e. trying to articulate a single philosophy or insisting that everyone adopt it.

This means that a recovery-oriented practice should emphasize that the relationship between the clinician and the consumer and carer should shift from "fixing" individuals and correcting their deficits to removing barriers and creating access through accommodation and promotion of health and wellbeing. For immigrants and refugees, this means that services consider the language barriers and ask for interpreters when needed, consider the relative meaning of mental illness and adopt a culturally responsive approach. Practitioners should incorporate social inclusion in their recovery-oriented practice by supporting immigrants and refugees to be more socially connected and to access education, employment and housing.

We should continue to have discussions about the philosophical traditions that inform this one, so that we are aware of what's being assumed and how this discussion relates to other social movements. We should be overt about insisting that service providers work with service users in ways that are consistent with the broader civil and political rights that are recognised in Australian law and commonly held to be important civil values. In a diverse society such as Australia, this includes respecting cultural rights and respect for family life just two of many international human rights covenants which apply here.

<< Toward a shared understanding of what recovery means in mental health practice and service delivery >>

[4] Sade M. (2009), *Personal recovery and mental illness: a guide for mental health professionals*. Cambridge University Press.

In this document, the term 'recovery' is considered an overarching philosophy that encompasses notions of self-determination, self-management, personal growth, empowerment, choice and meaningful social engagement. It is an overarching philosophy that does not equate with a particular model of care, phase of care or service setting.

It is an overarching philosophy that can be used to guide practice across the full range of clinical and non-clinical services.

The concept of recovery is understood to refer to a unique personal experience, process or journey that is defined and led by people in relation to their wellbeing and mental health.

Recovery is about building a meaningful and satisfying life, as defined by the person, whether or not there are any ongoing or recurring symptoms or difficulties.

While recovery is owned by and unique to each individual, mental health services have a role in creating an environment that facilitates clinical recovery and supports people's individual recovery efforts. An important goal of mental health services is minimising service system barriers to recovery.

Mental health services also have a role in supporting people with the effects of discrimination and other possible social consequences of the experience of mental illness including loss of self esteem, and limitations to social, housing and employment opportunities that might impede recovery.

3. What is your response to this statement as a starting point for developing a shared understanding of what recovery means in mental health practice and service delivery?
How might it be improved?

The initial statement emphasises "self-determination" etc. and "personal growth" are consistent with Western forms of individualism but these are not universally shared concepts by considerable proportion of the Australian community, particularly those from collectivist cultures.
To include the specific challenges of immigrants and refugees who can be isolated and disenfranchised due to cultural and linguistic barriers, we suggest including the following:

- It (recovery) is a journey that cannot be taken alone and requires involvement of the whole family, a strong network and culturally and linguistically competent care givers;
- It involves a collaborative endeavour involving the consumer, their family and the service provider;
- It also embraces the role of spirituality as an important lever to recovery;
- It cannot succeed in an environment that supports prejudice, discrimination and racism.

<< Toward a shared understanding of recovery journeys in mental health practice and service delivery >>

4. In viewing personal recovery as a journey, it is helpful to seek to identify, without being prescriptive, key processes and stages of that journey?

The processes and stages identified by the different authors all conclude in the goal of taking control over one's life which is positive but can also be seen by people from other culture as just one of the goal one who suffers mental illness could aim for. We shouldn't attempt to prescribe key processes or stages. We should investigate each unique person's/family's way of explaining what has happened to them, what they expect and what they believe will assist them. Recovery is not a linear process, but has highs and lows, forward movements but also sometimes backward movements. The key to recovery is consistency of positive support and hope.

5. Does viewing recovery as a journey comprising processes and stages also provide a conceptual basis for understanding the importance of recovery-oriented practice in involuntary, forensic and other secure settings where choice and responsibility might be most compromised?

All of the above applies to person's who are in involuntary, forensic and other secure settings.

6. What is your response to the Andresen, Caputi & Oades (2003 & 2006) conceptual approach to the processes and stages of personal recovery?

The processes and stages proposed by Andersen et al seem based on a Western form of individualism and, as such, do not cover the range of stages and processes of recovery for all members of Australian society. Other processes and stages could also be considered as focus groups, done with individual in the process of recovery,[5] tell us.
Safety and security – being in an environment where individual feel safe and secure to undertake their journey to recovery – is identified as a process vital for their recovery.

[5] Whitley R., Harris M., Fallot R.D., Wolfson Berley R. (2008), The active ingredients of intentional recovery communities: Focus group evaluation, *Journal of Mental Health*, 17 (2) 173-182

7. Are you aware of different approaches to understanding what the concept of 'recovery as a journey' means in mental health practice and service delivery?

Arthur Kleinman's (USA) work on negotiating explanatory models of illness provides an excellent foundation for a recovery model. Foundation House (Victoria Foundation for Survivors of Torture and Trauma) describes an approach to recovery from trauma related mental illness that includes an understanding of resilience. Larry Davidson's approach (USA). The framework adopted by NEAMI Victoria. And the one adopted by NorthWestern Mental Health Network, Melbourne Health.
The Mental Health Commission of Canada[6] includes the following key principle to address the issues faced by migrants and refugees:
Cultural safety and cultural competence are complementary frameworks that encourage service providers to take social, political, linguistic and spiritual realities into account.

<< Toward a shared understanding of key components of recovery-oriented mental health practice for individual practitioners >>

A synthesis of the research and literature suggests that key components of recovery-oriented practice for individual practitioners include:

- Collaborative relationships with people to understand each person's strengths, wishes and opportunities

- Responsiveness to the particular strengths, preferences, concerns, needs, goals and values of individuals responsiveness to the things, people, activities and roles that people identify as important to their wellbeing and recovery (and ensuring that mental health care enhances rather than interferes with these)

- Promoting decision making led by people accessing the services in accordance with each person's values, needs, circumstances and resources

- Encouraging and promoting self-determination and self-management of mental health and wellbeing

- Demonstration of empathy and resourcefulness in communicating with and responding to people

- Active challenging of stigmatising attitudes within the service and the broader community utilising people's existing support networks

- Use of interventions that promote people's personal agency, self-esteem and overall wellness

[6] Mental Health Commission of Canada (2009), Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada.

- Active listening and responsiveness to people's views, understandings of their experiences and advice on what they find helpful

- Use of person-centred and optimistic language that promotes hopefulness

- Practice that is trauma-informed and promotes safety

- Practice that is responsive to and inclusive of family, friends and peers

- Practice that is responsive to gender, sexuality, culture and community

- The offering of professional training, knowledge, expertise and experience as a resource for recovery

8. What is your response to the list of key components of recovery-oriented practice for individual practitioners provided in this Discussion Paper?
What changes or additions would you suggest?

The components listed cover most of the attitudes, skills and competencies of a recovery-oriented practice and could be grouped under those headings.
Culturally sensitive or responsive practice should be included here because this extends beyond responding to what the presenting person identifies as important to their wellbeing. It includes understanding:

- The person's cultural identity as a basis for understanding how he/she sees self, kinship and relation to broader community,
- His/her explanatory model of illness
- The interplay of cultural and psychological factors
- The practitioner's own language, cultural beliefs and values and how this impacts on interactions with the presenting person and family members.

These elements should be part of every recovery assessment and plan; they are relevant considerations for all service users regardless of ethnic/cultural background.
We also need to clearly state that responding to the person's family, in particular his/her carers is part of recovery-oriented practice. Cares and family members may need support, information, counselling and education in their own right in order to fulfil their caring role or to cope with the impact of mental illness on family life.
Since recovery relies on social inclusion, a key element for practice is working with other organisations that can support employment, education and housing. For culturally and linguistically diverse communities, the role of elders, traditional healers, and spiritual leaders are recognized and respected.

<< Toward a shared understanding of key components of recovery-oriented mental health practice at an organisational and service level >>

A synthesis of the research and literature suggests that key components of recovery-oriented practice at the organisational level include the following.

- Organisational culture and commitment to facilitate a reorientation to a recovery approach and the embedding of recovery principles in practice

- Inclusion of recovery principles in all management processes, such as recruitment, professional development, supervision, appraisal, audit, service planning and operational policies

- Incorporation of recovery values and language into all key organisational documents and publications

- A degree of risk tolerance in encouraging people's choice, balanced with duty-of-care obligations

- Routine documentation of people's preferences, ambitions, resources and support networks ongoing provision of information in multiple forms to people regarding rights, complaint processes, treatment options, advocacy support options and access to records

- A peer support workforce

- Involvement of people with lived experience and their significant others in processes such as recruitment, education, training and development, and quality-improvement activities responsiveness to people's feedback, for example, through using outcome-measures, surveys, quality audits, complaints, service planning and evaluation activities and training led by people with lived experience

- Providing evidence-based interventions that assist in achieving the best outcomes for people's mental health and wellbeing

- Using practice models compatible with a recovery approach such as strengths-based approaches and individual recovery planning

- Fostering partnerships between the service, people accessing services and their significant others

- Partnerships between different service providers for integrated and coordinated care

- Partnerships with community to aid social inclusion of people in communities of their choosing

9. What is your response to the list of key components of recovery-oriented mental health practice for organisations and services as detailed in Victorian Framework for Recovery-oriented Practice and provided in this Discussion Paper?
What changes or additions would you suggest?

The proposed list is extensive and could be grouped under components like information, management… for better understanding.
Any work to improve mental health service delivery at an organisational level needs to consider that people from immigrant and refugee backgrounds significantly underutilise main stream mental health services, even though the mental health needs of these groups are known to be high. Current initiatives that address this access and equity issue include improving the cultural responsiveness of mental health services and enhancing the capacity of community based organisations to respond.
We also know that considerable amount of support to people from immigrant and refugee backgrounds experiencing mental health issues is being provided by non specialist primary health services and ethnic specific, multicultural and other community based organisations. Therefore these services elements should be included in system efforts to reform mental health service delivery.
The items included in the last paragraph – "fostering partnerships between different service providers for integrated and coordinated care" and "fostering partnership with community organisations to support the social inclusion" should be included as key components.

<< Toward a shared understanding of what a recovery-oriented framework for mental health practice and service delivery should comprise >>

A review of existing frameworks and guidance for recovery-oriented practice suggests that at a minimum, the components of a new national framework might comprise the following.

1 - Statements reflecting shared understandings of what recovery means in the contexts of practice and service delivery

2 - Guiding principles

3 - Domains of practice

4 - Capabilities for each practice domain for individual practitioners and for services

5 - Indicators

6 - Measurement approaches and processes

7 - Examples of good practice at an individual practitioner level

8 - Examples of good practice at a leadership level

9 - Examples of good practice at a service delivery level

10 - Workforce development strategies or pathways

11 - A research agenda to build the knowledge and evidence base and to inform ongoing improvement in practice and service delivery

10. The Discussion Paper suggests that the new national framework should at minimum have 10 components. What is your response to this suggestion?

Would you add, change or delete certain components?

Or would you suggest a different approach?

The proposed list contains 11 components. For each of these components, we would have to make sure that the specificities of immigrant and refugee situation are taken into account. Consistent with the Working with Maori Skill Set, language, spirituality and health and well-being are components that also influence the recovery journey of immigrants and refugees with mental illness and their families of their journey and their interactions with service providers. A person's engagement with the host society and his/her pre-migration and settlement history should also be considered.
Cross-cultural understandings of recovery in Australia should be included as part of the research agenda and findings used to inform the development of principles, guidelines and approaches to measurement.

<< Toward a shared understanding of how the new national recovery-oriented mental health framework should approach the question of measurement? >>

11. What is your response to the examples of measurement processes and tools discussed in this paper? **How do you think the framework should approach the question of measurement?** **Should the framework recommend a set of tools?** **Alternatively, should services be encouraged to develop their own measures or adopt existing measures of their choice?**
Measures are always more reliable when they are closely linked to practice and as such, services should be encouraged to develop their own measures as well as have examples of measures previously used. We need to develop culturally and linguistically appropriate measures that use simple English. The effectiveness of translating measures into community languages should be carefully explored and be the subject of research and consultation in its own right. Measures that encourage the consumer, their family and practitioner to openly comment on the effectiveness and helpfulness of interventions would be welcome. Some examples of this already exist in brief counselling / solution oriented literature by Miller and colleagues and have been adapted across cultures and settings[7].

Recovery and age groups

12. How can the new national recovery-oriented mental health practice framework best ensure applicability to all age groups?
Q 12-14 These questions should be explored through further consultation and research. Care needs to be taken in using language that emphasises "special needs" versus "rights and responsibilities" in relation to mental health. Equitable access to mental health services is the right of all Australian citizens. Government provided and funded services are obliged to provide services and programs

[7] Miller, S.D., Duncan, B.L &,Hubble. M.A (2004) Beyond integration: The triumph of outcome over process in clinical practice *Psychotherapy in Australia*. Vol 10 No 4. Pp. 2-29

that are culturally responsive, this includes recovery-oriented mental health services. We need to build the capacity and capability of services to achieve this.

Recovery and Aboriginal and Torres Strait Islander peoples

13. Should the new national framework seek to integrate the expectations and preferences of Aboriginal and Torres Strait Islander peoples as well as cultural concepts and understandings relevant to recovery and wellbeing?

If so, how might this best be achieved?

Applicability of recovery-oriented approaches to difficult settings

14. Are there any limits to the application of recovery-oriented practice and service delivery?

Are there any settings or circumstances where the implications for adopting and implementing recovery approaches need to be identified and addressed in the new framework?

Many thanks for taking the time to think about these questions and for completing this survey. Your comments will help us with the next phase of the project.

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Kind regards,
Leanne Craze.