

**IN THE MATTER OF THE ROYAL COMMISSION
INTO FAMILY VIOLENCE**

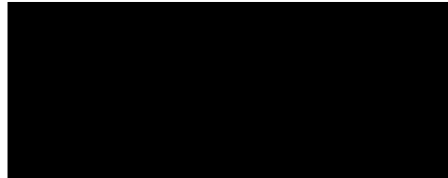
ATTACHMENT MOB-7 TO STATEMENT OF DR MARK OAKLEY BROWNE

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This is the attachment marked '**MOB-7**' produced and shown to **DR MARK OAKLEY BROWNE** at the time of signing his Statement on 17 July 2015.

Before me:



A national framework for recovery-oriented mental health services

GUIDE FOR PRACTITIONERS AND PROVIDERS



Australian Health Ministers'
Advisory Council



A national framework for recovery-oriented mental health services

GUIDE FOR PRACTITIONERS AND PROVIDERS

A national framework for recovery-oriented mental health services: Guide for practitioners and providers

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Foreword

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

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

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


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

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

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

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

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



Dr Peggy Brown

Chair

Australian Health Ministers' Advisory Council

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Acknowledgements

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

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

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

Appreciation and thanks are extended to the many people who provided extensive feedback and comments during the development of the framework, particularly to those people with a lived experience, their carers and mental health clinicians who contributed so much of their time and expertise, participated in the public consultations and contributed their stories of lived experience. Thanks also to those who assisted in finalising the framework. Special thanks go to Dr Leanne Craze of Craze Lateral Solutions, the key author of the framework; and to Ms Pauline Miles and Ms Carolyn Fyfe, the artists whose works illustrate this guide.

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

Executive summary

About this document

This document is a guide for mental health practitioners and services to Australia's national framework for recovery-oriented mental health services. It provides definitions for the concepts of recovery and lived experience. It describes the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery-oriented principles. And it provides guidance on tailoring recovery-oriented approaches to respond to the diversity of people with mental health issues, to people in different life circumstances and at different ages and stages of life.

About the framework

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

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

The framework supports cultural and attitudinal change and encourages a fundamental review of skill mix within the workforce of mental health services, including increased input by those with expertise through experience.

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

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

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

The framework is presented in two documents.

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

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

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

Recovery: the concept

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

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

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

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

Personal recovery—a definition

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

Recovery-oriented mental health practice

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

Recovery-oriented practice encapsulates mental health care that:

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

Recovery-oriented mental health service delivery

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

Recovery-oriented mental health services have a responsibility to:

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

Recovery, self-determination and safety

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

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

Maximising people's self-determination requires continued efforts to reduce coercion, seclusion and restraint. However, involuntary assessment and treatment will continue to be necessary when there is no less restrictive way to protect a person's health and safety.

All Commonwealth and state legislation and standards governing mental health service provision emphasise the importance of working collaboratively with a person and their family irrespective of whether they are receiving treatment voluntarily or involuntarily, or whether that treatment is in a hospital or in the community. Self-determination is a vital part of successful treatment and recovery. The concepts of self-determination, personal responsibility and self-management and the goals of reclaiming control and choice are pivotal regardless of a person's legal status. For people who are treated under mental health legislation—that is, involuntarily—recovery-oriented care will have different characteristics at different phases of their treatment.

Domains of recovery-oriented practice and service delivery

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

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

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

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

Domain 2: Person 1st and holistic

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

Domain 3: Supporting personal recovery

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

Domain 4: Organisational commitment and workforce development

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

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

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

Capabilities

Capabilities for recovery-oriented practice and service delivery encompass underlying core principles, values, knowledge, attitudes and behaviours, skills and abilities. Individuals, teams and organisations need these capabilities in order to support people with mental health issues to live a meaningful and contributing life in their community of choice. The framework identifies 17 key capabilities within the five practice domains. Each capability is described with the following attributes:

Core principles that should govern all practice, decisions and interactions in the provision of mental health care within the relevant domain

Values, knowledge, behaviours and skills consistent with recovery-oriented practice

Recovery-oriented practice examples intended to support all mental health workers to translate principles of recovery into their daily practice

Recovery-oriented leadership examples directed at service leaders and managers that describe activities and governance structures that support and promote a recovery-oriented organisation

Opportunities and resources to guide and support implementation.

A detailed description of the domains and associated capabilities can be found in the Appendix at the end of this document. They are summarised in Table 1 below.

Table 1: Practice domains and capabilities

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

Conclusion

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

Application of this framework will contribute to improved mental health and wellbeing as people are supported in new ways to lead fulfilling and contributing lives. The framework will foster new and innovative service designs, and in particular services designed and operated by people with lived experience of mental health issues. All Australian jurisdictions and all mental health services have a responsibility to promote and implement the framework.

1 About this document

This document, *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*, gives an overview of the national recovery-oriented mental health practice framework and guidance on recovery-oriented practice and service delivery.

It includes discussion on and definitions for the concepts of recovery and lived experience. It describes the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery-oriented principles. And it provides guidance on tailoring recovery-oriented approaches to respond to the diversity of people with mental health issues.

The document is intended for all people employed in mental health service sectors², regardless of their role, profession, discipline, seniority or degree of contact with people accessing services. This includes consumer/family consultants and the peer workforce, practitioners, psychosocial and recovery support workers, Aboriginal and Torres Strait Islander health workers, social-emotional wellbeing workers, service managers and team leaders. It also includes people in administration, mental health policy development, research, program management and service planning.

This document will also be useful for professionals in other service systems who contribute to the wellbeing of people with mental health issues and who support their personal recovery efforts.

More information about the policy and research underpinnings of the framework is provided in the companion document to this guide, *A national framework for recovery-oriented mental health services: Policy and theory* available at www.health.gov.au/mentalhealth.



*Journey of hope and
new beginnings*

The Journey Pauline Miles ©

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

2 About the framework

The National recovery-oriented mental health practice framework is a vital new policy direction to enhance and improve mental health service delivery in Australia.

It brings together a range of recovery-oriented approaches developed in Australia's states and territories and draws on national and international research to provide a national understanding about what constitutes recovery-oriented practice and service delivery, and how recovery-oriented models can be translated into practice. It complements existing professional standards and competency frameworks.

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

The framework is presented in two documents:

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

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

Lived experience—the heart of the framework

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

Bringing lived experience together with the expertise, knowledge and skills of mental health practitioners offers opportunities for profound cultural change in the way it challenges traditional notions of professional power and expertise. Given that a significant proportion of the mental health workforce has lived experience of mental health issues either in their own lives or in their close relationships, recovery paradigms help to break down the conventional demarcation between staff and people who use services. Within recovery paradigms all people are respected for the experience, expertise and strengths they contribute.

...people with lived experience are considered experts on their lives and experiences while mental health professionals are considered experts on available treatment services.

Victorian Department of Health (2011).

Purpose of the framework

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

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

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

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

The language of recovery

Consistent with the language of recovery, the terms 'person', 'person in recovery', 'person with lived experience', 'lived expertise' and 'expert by experience/training' are used wherever possible rather than the terms 'clients', 'service users' or 'patients', which focus on deficits or relationships to services (Recovery Devon 2012). For similar reasons, the framework uses the term 'family and support people,' which includes family members, partners, friends or anyone whose primary relationship with the person concerned is a personal, supportive and caring one.

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

Relationship to Australia's mental health service standards

Australia's *National Standards for Mental Health Services 2010* underpin this framework. Of particular importance are the 'Principles of recovery oriented mental health practice' and the 'Supporting recovery' standard (Standard 10.1). The mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and wellbeing measures. The 'Principles of recovery oriented mental health practice' are intended to inform and overarch all ten standards.

Organisations that provide mental health or allied services can use the national mental health standards to assess the recovery orientation of their services. A number of other tools that assess an organisation's recovery orientation are identified in the section entitled 'Recovery-oriented service delivery'.

More detail on the relationship between the national mental health standards and the framework can be found in the companion to this document, *A national framework for recovery-oriented mental health services: Policy and theory* available at www.health.gov.au/mentalhealth.

Who is this Framework intended for?

This framework is for anyone who is interested in embedding recovery-oriented care into their practice.

How to use this guide

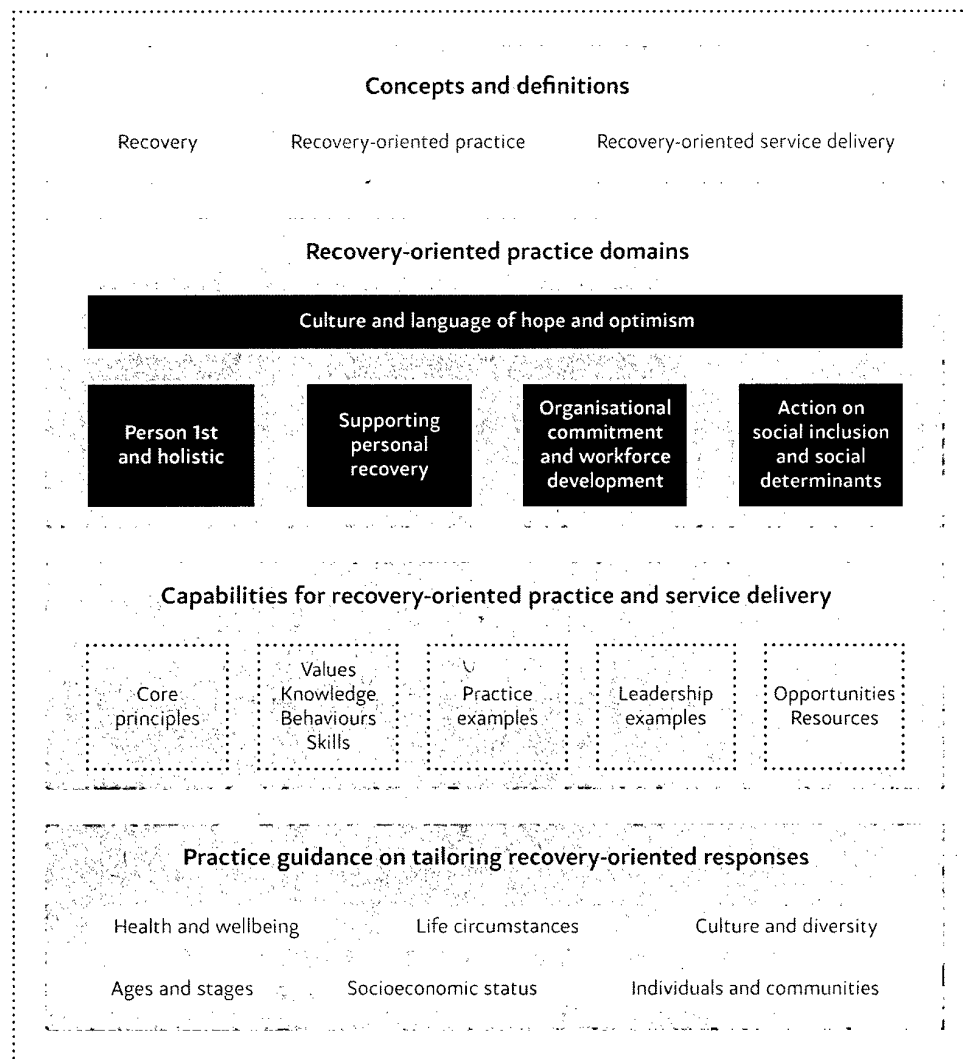
The guide covers many areas of practice with detailed suggestions about how to achieve recovery-oriented practice. Some practitioners and providers may find it helpful to concentrate on particular areas of interest as well as viewing the framework as a whole.

Section 9 and the Appendix contain detailed information on each of the practice domains and key capabilities required.

A diagram representing the national recovery framework at a glance is at Figure 1.

Figure 1: The national framework for recovery-oriented mental health services: at a glance

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



3 Recovery: the concept



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

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

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

Some characteristics of recovery commonly cited are that it is:

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

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

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

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

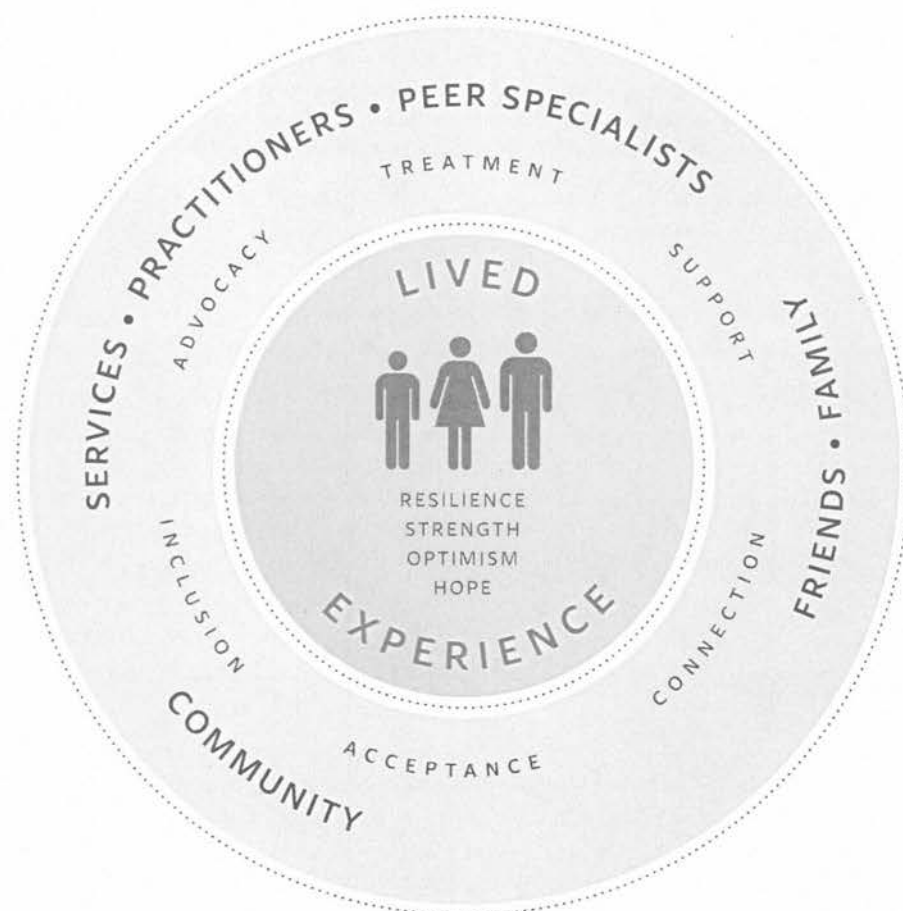


The personal view of recovery is viewed as a journey that is a unique and personal experience for each individual. It has often been said to be about: gaining and retaining hope, understanding of one's abilities and limitations, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. Essentially, the personal view of recovery is about a life journey of living a meaningful and satisfying life.

NSW Consumer Advisory Group (2012)

The concept of recovery is represented in Figure 2 below.

Figure 2: The concept of recovery



Conceptual models of recovery processes

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

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

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

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

Glover (2012)

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

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

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

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

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

This study analysed 30 international documents to identify the key characteristics of recovery-oriented practice guidance. The researchers developed an overarching conceptual framework to aid the translation of recovery guidance into practice.

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

Viewing recovery as a normal human process 'demystifies' the process of recovery from mental health problems and puts people in a better position to support someone in their recovery journey.

NSW Mental Health Coordinating Council (2008).

[Recovery is] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

William Anthony (1993).

4 Recovery-oriented practice

Capabilities for recovery-oriented mental health practice

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

Capabilities for recovery-oriented practice and service delivery encompass underlying core principles, values, knowledge, attitudes and behaviours, skills and abilities.

Individuals, teams and organisations need these capabilities in order to support people with mental health issues to live a meaningful and contributing life in their community of choice. Attaining and strengthening these capabilities is an ongoing process that takes time and commitment from leaders, professionals, staff and volunteers in mental health service provision.

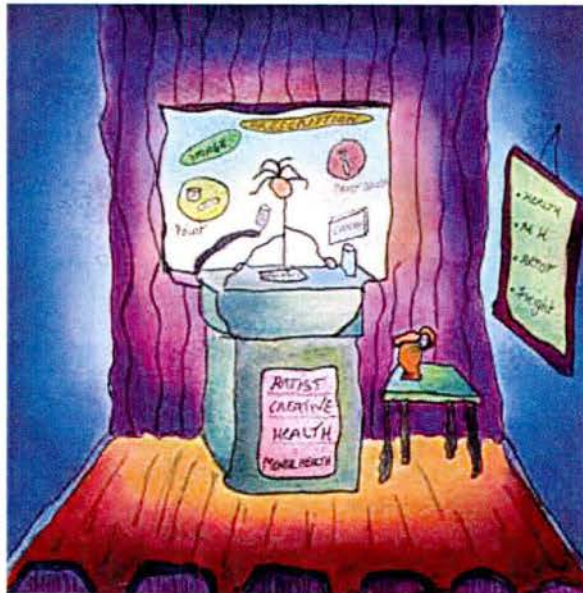
Recovery-oriented practice is understood in this framework as encapsulating mental health care that:

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

Measuring individual recovery

The Australian Mental Health Outcomes and Classification Network *Review of recovery measures* (Burgess, Pirkis, Coombs & Rosen 2010) identified four recovery outcome measures:

- Recovery Assessment Scale (RAS)
- Illness Management and Recovery (IMR) Scales
- Stages of Recovery Instrument (STORI)
- Recovery Process Inventory (RPI).



The Advocate Pauline Miles ©

*Recovery is different
for everyone*

5 Recovery-oriented service delivery

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

Service delivery is centred on, and adapts to, people's needs and aspirations rather than people having to adapt to the requirements and priorities of services. Recovery-oriented services welcome all people and afford them respect and safety.

Recovery is a vision and commitment shared at all levels of an organisation. The vision is sustained by a diverse, appropriately supported and resourced workforce that includes people with lived experience. It includes peer-run programs and services.

Recovery-oriented service delivery takes into account the fact that people with unresolved trauma struggle to feel safe. The possibility of unresolved trauma is acknowledged in all service settings and the core principles of trauma—safety, choice, collaboration, trustworthiness and empowerment—are incorporated into service provision.

Services recognise and respond to Aboriginal and Torres Strait Islander cultures, values, belief systems and perspectives of identity, family, mental health, health and wellbeing. They respond to the trauma experienced by Stolen Generations and Forgotten Australians.

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

A recovery-oriented mental health service acts within its legislative and budgetary settings to:

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

Tools to assess the recovery orientation of mental health and allied services

The Australian Mental Health Outcomes and Classification Network *Review of recovery measures* (Burgess, Pirkis, Coombs & Rosen 2010) has identified four tools designed to measure the recovery orientation of services.

- Recovery-oriented Systems Indicators Measure (ROSI)
- Recovery Self-assessment (RSA)
- Recovery-oriented Practices Index (ROPI)
- Recovery Promotion Fidelity Scale (RPFS)

Slade (2009b, p. 25) suggests a number of other measurement tools.

- *Practice guidelines for recovery-oriented behavioral health care*, Connecticut Department of Mental Health and Addiction Services (2006)
- Fidelity Assessment Common Ingredients Tool (FACIT), a fidelity measure for peer-run services
- Pillars of Recovery Service Audit Tool (PoRSAT), a measure to inform service development
- Recovery-promoting Relationships Scale, a consumer-rated measure of the extent to which relationship supports recovery processes.

The *Review of recovery measures* suggests the following criteria that organisations might apply in any tool they use to measure their recovery orientation. An essential criterion is that people with lived experience have led or contributed to the tool's development. In addition, any tool should:

- explicitly measure domains related to personal recovery or the recovery orientation of services
- be brief and easy to use (≤ 50 measures for personal recovery domains and ≤ 100 measures for services' recovery orientation)
- take a consumer perspective
- yield quantitative data
- have undergone appropriate processes of development, piloting and documentation, and ideally been scientifically scrutinised
- be applicable to the Australian context
- be acceptable to people with a lived experience
- promote dialogue between providers and people with a lived experience.

Organisations should also use Australia's *National Standards for Mental Health Services 2010* to assess the recovery orientation of their mental health services. More detail on the relationship between the national mental health standards and the framework can be found in the companion to this document, *A national framework for recovery-oriented mental health services: Policy and theory* available at www.health.gov.au/mentalhealth.

6 Recovery, self-determination and safety

Mental health practice and service delivery consistent with recovery principles requires an emphasis on maximising choice and self-determination. It also requires a reduced reliance on coercion, seclusion and restraint.

In situations where there is no less restrictive way to protect a person's health and safety, involuntary assessment and treatment may be necessary. In this situation a recovery-oriented approach works within and complements the legislative framework that is in place to protect the rights and safety of people in involuntary treatment. Even in situations where certain treatments or medications are not a person's own choice, interventions can still be provided from a recovery orientation, recognising that self-determination is a vital part of successful treatment and recovery. An important aspect of treatment in the involuntary setting is to support the person to regain their capacity to make informed decisions.

National action to develop best-practices approaches to reducing coercion

The National Mental Health Seclusion and Restraint Project (NMHSRP) 2007–09 promoted discussion and action to reduce two forms of coercion—seclusion and restraint. The project demonstrated that simple changes can lead to major improvements. Australian state and territory governments as well as professional associations embraced the objectives of the NMHSRP and reviewed their policies and practices.

The NMHSRP included the establishment of 11 Beacon demonstration sites across Australia to develop and implement best-practice initiatives and become centres of excellence for the reduction and, where possible, the elimination of seclusion and restraint. Findings from the Beacon demonstration sites suggest that there has been a decrease in the amount of time people are being secluded, although seclusion events are influenced by a range of different factors related to people's specific circumstances and service responses. The following strategies were identified as influencing positive outcomes to reduce seclusion: leadership to effect organisational change, the use of data to inform practice, investment in workforce development and debriefing techniques involving people with a lived experience, their carers and staff.

Minimising risk and maximising opportunities for positive-risk taking and positive learning

Helping a person to regain control, choice and decision making and attain self-determination, personal responsibility and self-management requires practitioners and services to confront the challenge of reducing and removing coercion while reducing harmful risks and increasing opportunities for positive risk-taking and positive learning (Slade 2009a).

Therapeutic relationships are key in the management of safety. Robust, mutually respectful and trusting, diverse, active and participatory relationships between the person with mental health issues and the service provider will contribute to that person's successful management of their own safety.

Practice responses to support self-management

Practitioners can use the following approaches to support self-management:

- joint or supported decision making about the management of risk and promotion of safety including consideration of sensory modulation strategies to manage distress/arousal
- jointly constructed service plans and early warning sign/relapse signature plans (Rosen, Rosen & McGorry 2012)
- recovery and wellbeing plans and recovery workbooks
- inclusion of family and carers in opportunities for positive risk taking and learning.

Trauma assessment processes might also be helpful, for example, prevention plans that identify triggers and early signs and collaborative strategies for preventing and de-escalating agitation.

Psychiatric advance directives

Psychiatric advance directives—also known as mental health advance directives or Ulysses agreements in the disability field—have an important role to play (Slade 2009a, pp. 160–171). Advance directives or similar approaches help to reduce loss of autonomy and increase a person's sense of control when they have temporarily lost capacity to make reasoned and informed decisions. Though they are not yet legally binding throughout Australia, their use is widely encouraged by mental health services. Advance directives are empowering as they enable a person to indicate their views, wishes and preferences while they are well. Advance directives guide mental health practitioners in keeping a person's values and wishes foremost during a crisis (Topp & Leslie 2009).

Addressing tensions

A recovery orientation requires services to confront the tension between maximising choice and supporting positive risk-taking—or the dignity of conscious risk-taking on one hand and duty of care and promoting safety on the other. Striking a balance requires an understanding of the illusory, damaging and sometimes discriminatory nature of the goal of reducing harmful risks (Slade 2009a, pp. 176–179).

Australian provisions governing involuntary mental health intervention do not preclude people from consenting and participating in treatment choices, to the extent that is possible in the given circumstances. The concepts of self-determination, personal responsibility and self-management and the goals of reclaiming control and choice are pivotal regardless of a person's legal status. Australian mental health statutes emphasise the importance of working collaboratively with a person and their family irrespective of whether they are receiving treatment voluntarily or involuntarily and irrespective of whether that treatment is in hospital or in the community.

The importance of transparency

A recovery-oriented practice approach requires transparency. For example, during involuntary interventions practitioners need to recognise and acknowledge that the intervention, while deemed medically necessary, is at odds with the person's self-determined choice.

Recovery principles encourage open and honest discussion and negotiation between practitioner and consumer about any legal requirements. Choice and learning can be promoted even in the most restrictive settings, including forensic and other security settings.

Values-based practice training can assist in situations where different (and hence potentially conflicting) values are at play (Woodbridge & Fulford 2004).

Critical appraisal in decision making about risk and its management

Recovery-oriented approaches encourage critical appraisal of the criteria and questions used in evaluating risk and in determining risk-management arrangements, including the need for involuntary intervention (Slade 2009a, pp. 184–189). In considering the least restrictive treatment alternative possible, practitioners and services should also consider whether, to the extent it is possible in the given circumstances, the proposed involuntary intervention:

- increases or decreases the person's ability to self-regulate and self-manage their emotions and behaviour
- respects the person's choice, values and preferences
- enables the person to perform as many life skills as possible and connect with their regular life
- maximises the person's connection with close relationships, support networks and community
- augments the person's positive sense of self and draws upon their strengths
- offers opportunities for a person to learn new skills, maximise their potential or connect with their inherent strengths.

Another important consideration is how a treating team's decision to use coercion will be interpreted by the person and their family members. This is particularly important when working with Aboriginal and Torres Strait Islander peoples, Forgotten Australians and people from immigrant and refugee backgrounds who have experienced high levels of trauma as a result of having been forcibly removed from people important to them, particularly from family. Close contact with others may be key to healing and recovery.

Understanding cultural idioms

Misinterpreting cultural idioms of distress can lead practitioners to overestimate or underestimate the degree to which an individual risks harming self or others. Cultural sensitivity training, supervision and support, and the involvement of bilingual practitioners, cultural advisers, interpreters and transcultural peer workers can increase practitioner confidence and competence around making these challenging clinical judgements.

Organisational strategies

Organisations can use the following strategies (Slade 2009b) to strike a beneficial balance between maximising choice and maximising safety.

- Audited and organisationally supported processes can be used to assess, develop and document actions on reducing harmful risks.
- Increasing the organisation's focus on positive risk-taking, and providing people with opportunities to experience positive challenges and positive learning helps people to self-manage their own safety. Audited and organisationally supported systems can be used to assess, plan and document these opportunities.

Actions to reduce harmful risks should be decided with each person through a process of open discussion. Differing views are identified and negotiated in order to arrive at a consensus or middle ground (Slade 2009a, pp. 178–179).

Where possible, clinical decisions should be made by multidisciplinary teams that include peer specialists, rather than by an individual practitioner in isolation (O'Hagan, Divis & Long, 2008; Te Pou 2011; Slade 2009a, p. 179).

Service responses for promoting safety and reducing coercion

Convenient and early access to services—for example, through after-hours mobile services—as well as early detection and engagement will reduce the need for coercion and involuntary interventions. Other service responses include:

- providing staff with training in non-forceful therapeutic crisis intervention, including sensory modulation strategies
- maximising the availability of quiet and safe places and spaces within inpatient facilities that provide personalised environments conducive to harmony, engagement and entertainment (NMHCCF 2009).

The importance of safe, respectful and welcoming service environments

Risk is reduced when people feel respected, acknowledged, listened to and valued. Facility design that creates a welcoming and homely environment, that enables the ongoing use of everyday living skills, and allows people to engage in important relationships are also important (O'Hagan, Divis & Long 2008; Slade 2009a; Adams & Grieder 2005; Rosen, Rosen & McGorry 2011).

When involuntary hospitalisation cannot be avoided, recovery-oriented services provide appropriate and respectful transport options and minimise trauma.

The contribution of peers to reducing coercion

A growing body of evidence supports the role and efficacy of peer-designed, developed and operated services in promoting recovery, preventing crises, reducing unnecessary admissions and reducing the need for coercion. The use of peer workers contributes significantly to shortened lengths of involuntary admissions, decreased frequency of admissions and readmissions, and a subsequent reduction in the long-term need for mental health inpatient services and the use of involuntary interventions (Frost et al. 2011; Institute of Medicine 2006).

While formal evaluation of peers is required in this context, promising examples include:

- peer-welcoming services (The Living Room, Recovery Innovations, Phoenix, Arizona)
- peer-run warmlines (Phone Connections, Consumer Activity Network, Sydney)
- peer-run support upon discharge from hospital (Hospital to Home, Consumer Activity Network, Sydney)
- peer-run residential services (the Brook RED Centre and the FSG Australia in Queensland; Key We Way in Wellington, New Zealand).

Evaluative studies will clarify and strengthen the evidence base. This will maximise the contribution of peers and maintain the integrity of their peer role.



I remember my children coming to visit me in the hospital and at the time I was considered a danger to my children and myself. My children wanted to go outside on the grass to play ... My daughter fell down a manhole in the hospital grounds and she needed stitches in her leg. The hospital was very quick and helpful at arranging for me to be accompanied to the A&E with my daughter. She wanted her mum with her at a time of great distress and this was allowed to happen. This helped me in my self-esteem around being a parent and was very important in aiding my recovery and bond to my children.

A person in a forensic facility, quoted in Roberts et al. 2008, p. 178.

Interventions in involuntary settings can still be provided from a recovery orientation, which recognises that self-determination is a vital part of successful treatment and recovery.



The Journey—Rowing My Own Boat Pauline Miles ©

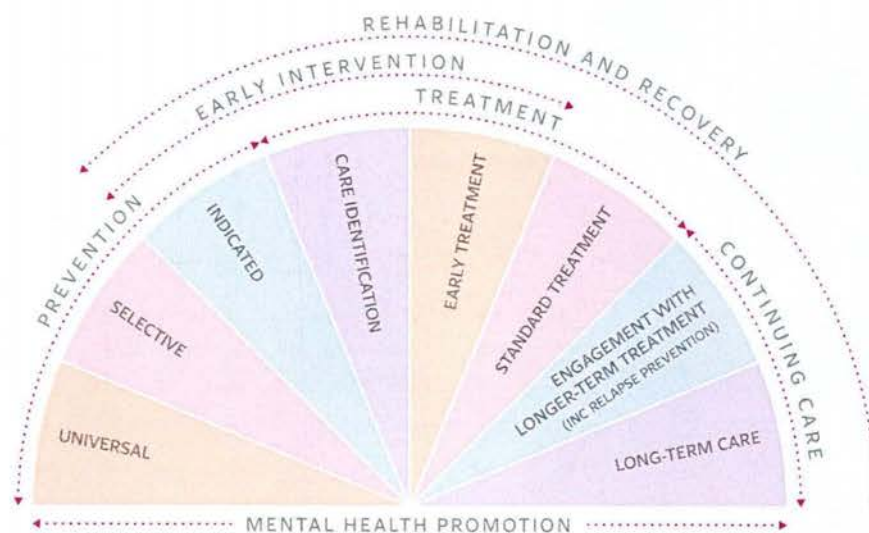
Maximising choice and self-determination

7 Recovery across the mental health service spectrum

Recovery-oriented approaches can be implemented across the full spectrum of services, from community supports to primary health care and hospital-based care. Figure 3 depicts the relationship between recovery practice and service delivery, rehabilitation and other mental health interventions.

Commonwealth, state and territory policies stress the need for rehabilitation to commence at the earliest possible point in a person's recovery (Queensland Health 2005; Tasmanian Department of Health and Human Services 2009; NSW Health 2006; SA Health 2012).

Figure 3: Recovery practice along the continuum of mental health interventions



Source: NSW community mental health strategy 2007–12: from prevention and early intervention to recovery (2006)

A recovery approach in rehabilitation services

In Australia, rehabilitation services are provided by all mental health service sectors—public, private and non-government. Rehabilitation services work across service settings—inpatient to community based—and across the life span.

The Australian non-government mental health service sector is a significant provider of continuing care and rehabilitation and recovery services. This sector has defined their core service components as:

- accommodation support and outreach
- employment and education
- leisure and recreation

- family support and carer programs
- self-help and peer support
- helpline and counselling services
- information, advocacy and promotion (MHCC 2010).

A helpful definition of rehabilitation in the context of recovery

Services play a key role in supporting the recovery process for people with mental health issues by helping them to access the internal resources they need in their recovery (for example, hope, resilience, coping skills, self-acceptance and physical health) and the external services and supports that support recovery and independence (for example, stable accommodation, education and vocational support). Rehabilitation plays an important role in promoting hope, redefining identity, building personal control and finding meaning and purpose by using a strengths-based and wellness-oriented approach. The aim of recovery-focused rehabilitation is to enable people to live meaningful lives in the community and to achieve their fullest potential (NSW Health 2008; Russinova 1999).

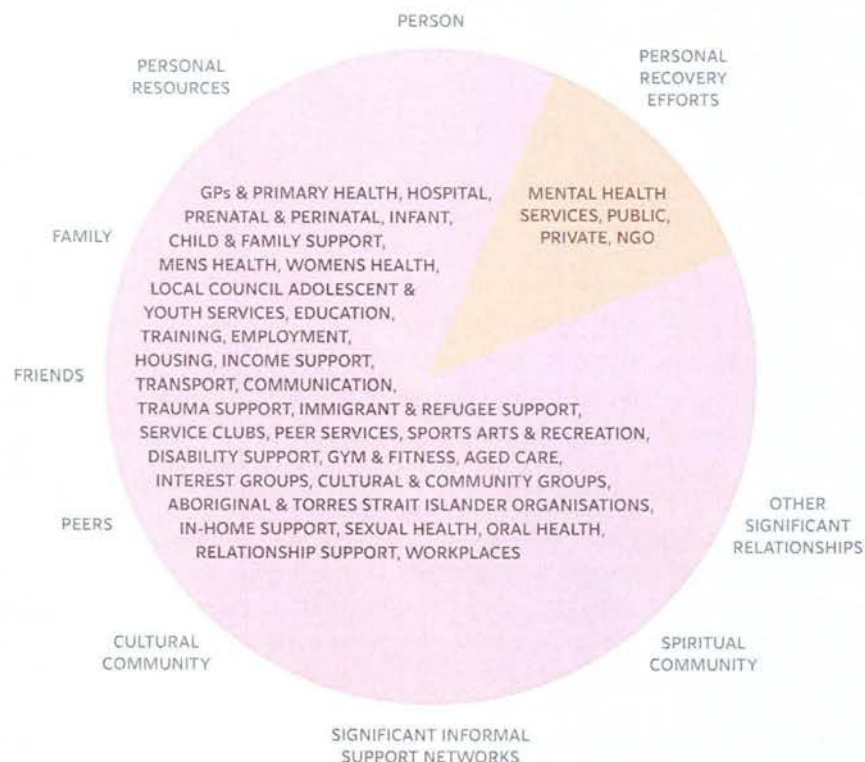
Principles underpinning rehabilitation service provision

- Rehabilitation is not the same thing as recovery.
- Best-practice rehabilitation is recovery oriented.
- Rehabilitation services are not the only vehicle for recovery—they are one component of a service system that collectively works towards the recovery of individuals.
- Rehabilitation should be available in all settings and begin as soon as possible.
- Rehabilitation practices should always encompass purposeful best-practice interventions.
- Rehabilitation occurs on a continuum, and all workers need to understand rehabilitation, but not everyone needs to be an expert in providing all interventions.
- The process of establishing a positive therapeutic relationship is a part of the rehabilitation continuum, and it takes effort and time.
- Trauma-informed approaches are integral to a recovery-oriented approach and should be embedded in rehabilitation service culture, policy and practice.
- Rehabilitation techniques provide a range of tools that can be used to help an individual to gain or regain their independence and strive towards their recovery.
- Rehabilitation services that are shaped by the goals of promoting hope, healing and empowerment foster an underlying attitude that recovery is possible, offer opportunities for people to maximise their own experience of recovery and create a service environment that is flexible, responsive and accessible (SA Health 2012).

8 Recovery within the broader context

Many factors outside the mental health service system impact on an individual's recovery process. Government, private and non-government agencies from other service sectors have a role in helping people to maximise their quality of life. Figure 4 shows some of these agencies, including providers of employment support, education, training and housing.

Figure 4: Groups involved in a person's recovery



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

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

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



The Kitchen Table Pauline Miles ©

*Most of a person's
recovery occurs at home*

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

The framework consists of 17 capabilities grouped into five dominant fields of practice known as 'practice domains'.³ The domains are overlapping and should be used concurrently.

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

A detailed description of the domains and associated capabilities can be found in the Appendix at the end of this document.

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

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

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

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

Domain 2: Person 1st and holistic

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

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

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

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

³ The domains are consistent with those identified in the Victorian Department of Health's *Framework for recovery-oriented practice 2011* as well with the practice development pathways identified in the Queensland Health and Community Services Workforce Council's *Values into action: community mental health practice framework* (2012). The domains and their capabilities are also consistent with the evidence-based schema of Le Boutillier et al. (2011).

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

Domain 3: Supporting personal recovery

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

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

Domain 4: Organisational commitment and workforce development

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

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

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

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

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

Describing the capabilities

Each key capability is described in detail in the Appendix using the following defining characteristics:⁴

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

⁴ This structure draws heavily on the Victorian Department of Health's *Framework for recovery-oriented practice* (2011).



10 Keeping diversity in mind

Research tells of the serious and compounding emotional problems experienced by people with mental health issues emerging from discrimination on account of ethnicity, race, culture or sexual orientation.

This section commences with a discussion of generic principles and practice for keeping diversity in mind in recovery-oriented practice and follows with some specific guidance for working with people and communities who are:

- Aboriginal and Torres Strait Islander
- from culturally and linguistically diverse backgrounds, including refugees and asylum seekers
- of different ages, including children, young people and older people
- lesbian, gay, bisexual, transgender and intersex
- living in rural and remote communities
- experiencing socioeconomic hardship and stress
- experiencing coexisting conditions and complex needs
- involved in the criminal justice system (including youth justice).

Some generic principles and practice⁵

Biological, psychological, physical, environmental, economic, social and political factors all impact on health and wellbeing at a personal, local and global level. Practitioners and services need skills for identifying potentially adverse or isolating impacts on a recovering person, and acting to prevent or mitigate those experiences. Recovery occurs within a web of relations including the individual, family and community, and is contextualised by history, culture, privilege or oppression and the social determinants of health. Recovery also occurs within the context of gender, age and developmental stages.

Recovery approaches are alert to the impacts on health and wellbeing, both positive and adverse, of diversity—whether they are socially, culturally or language based (Ida 2007, p. 49). Culturally and socially responsive practice entails an understanding of:

- a person's cultural identity as a basis for understanding how they see self, kinship and relations with the broader community
- a person's explanatory models of illness, distress and wellness
- experiences of torture, trauma, displacement, loss, racism and discrimination
- internalisation of stereotypes of mental illness and the burden of hiding personal identity (Deegan, G 2003)
- how spirituality, community, kinship and family can support recovery processes
- the impact of the practitioner's own language, cultural beliefs and values on the therapeutic relationship
- barriers to service.

⁵ The report written by Rickwood for the National Mental Health Promotion and Prevention Working Party, *Pathways of recovery: 4As framework for preventing further episodes of mental illness* (2006) commenced this discussion.

Practice skills are required that enable service delivery to:

- be in an appropriate ethnic or social language using the help of interpreters, bilingual counsellors, cultural advisers, peer support workers, community-based organisations and community leaders
- accommodate both collective and individual experiences of identity and respect specific spiritual, emotional, psychological and religious traditions
- be alert and responsive to the potential impact of an inherited history and continuation of collective trauma
- be multidisciplinary, multiagency, cross-sectoral and partnership based.

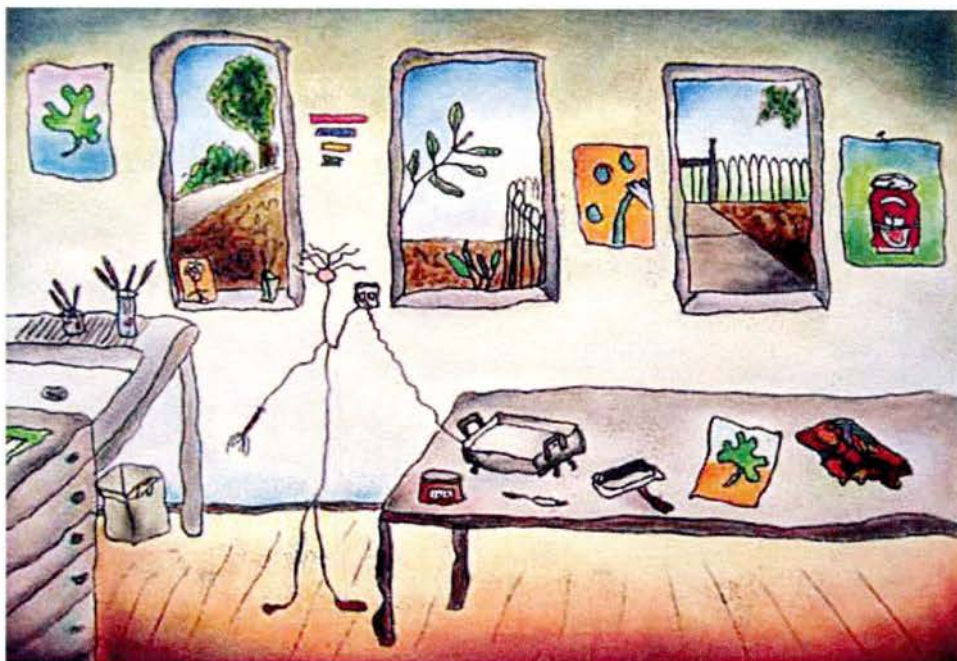
Culturally and socially sensitive service delivery requires customised procedures to:

- acknowledge the importance of relationships in an individual's recovery
- work with families, close relationships, support networks, elders, interpreters and cultural advisers from different cultural traditions
- provide physical and emotional environments in which people of differing ages and developmental stages and with differing cultural and social backgrounds feel safe and supported.

Integrating primary health, mental health, drug and alcohol and community and family services will support people who are trying to recover by reclaiming culture and reconnecting with community.

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

Pat Deegan (1996)



There Are Many Points of View Pauline Miles ©

Aboriginal and Torres Strait Islander people

The social and emotional wellbeing concept (SEWB) developed by Aboriginal and Torres Strait Islander peoples is broader than mainstream concepts and recognises not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. It also includes the cyclical concept of life–death–life (NAHSWP 1989).

Aboriginal and Torres Strait Islander constructs of self, identity and meaning are complex and diverse, incorporating families, kinship and extended clan groups. These constructs sit alongside an elaborate set of relational bonds and reciprocal obligations. They may also incorporate a profound sense of continuity through Aboriginal law, spirituality and Dreaming. Far from being anthropological artefacts, they directly influence daily interactions in urban, regional and remote settings.

The process of malignant grief that occurs in Aboriginal and Torres Strait Islander communities as a result of persistent intergenerational trauma and stress is invasive, collective and cumulative. It causes individuals and communities to become unable to function. Many people die of this grief (Milroy, cited in Parker 2011).

Many Stolen Generation survivors struggle their whole lives to heal from their experience of trauma. They are vulnerable to the retriggering of memories and feelings associated with their experience of forcible removal. Survivors maintain that these are human reactions not necessarily connected to mental health issues.

Implications for practice

- Learn about the diversity of Aboriginal and Torres Strait Islander experiences, cultural values and processes.
- Interpretations of health, mental health, mental illness and wellbeing are vital first steps in achieving culturally competent and safe practice.
- Support to cope with the distress invoked by triggers is part of the healing process for the Stolen Generations.
- Trauma-informed strategies can help to manage the risk of unintentionally triggering unresolved trauma.

Implications for service delivery

- Some common Western service models and responses can be inappropriate for Aboriginal and Torres Strait Islander people. For example, hospitalisation can be traumatic for some people due to their being removed from community and traditional ways of life. It can also trigger pain, trauma, loss and grief associated with invasion, colonisation, segregation, assimilation and more recent policies.
- Give priority to culturally appropriate practice and service alternatives, including Aboriginal community-controlled organisations.
- Seek advice and guidance from:
 - Aboriginal and Torres Strait Islander health and mental health practitioners
 - social–emotional wellbeing workers
 - Elders and leaders
 - cultural consultants
 - traditional healers
 - Aboriginal community-controlled health/SEWB organisations.
- Explore connections with Aboriginal and Torres Strait Islander services and local Indigenous-specific knowledge.

Resources

Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice (Purdie, Dudgeon & Walker eds. 2010).



'Guthlan' Carolyn Fyfe discusses her journey of recovery and healing.

The art is called the 'Journey' ... The journey of recovery and healing starts from the outer circle identifying the challenges that a person would experience. The colours:

Brown—the challenges to make the change in your thoughts/emotions (trying to move ahead)

Black are the dark times (depression)

Mauve—identified the reasons and have moved forward

White—you have the control

As you get closer to the centre it represents the wellness of health—socially, emotionally and spiritually.

It is a long journey and you need to have people who can let you explain your story and they theirs.

Journey 'Guthlan' Carolyn Fyfe ©

People and communities experiencing socioeconomic hardship

There are well-established links between physical health, mental health and wellbeing and social and economic hardship (Wilkinson & Marmot 2003) arising from interrupted education and training, unemployment, economic displacement, poverty and income insecurity, reduced access to affordable and nutritious food, housing stress, homelessness and isolation.

Implications for practice and service delivery

- Use principles of participation, engagement, empowerment and community development to form alliances and partnerships to advocate for action on socioeconomic factors impacting on health and wellbeing.

Culturally and linguistically diverse populations

People's experiences and relationships are mediated by cultural, social and historical contexts. In some cultures, individuality and personhood are not emphasised as much as kinship and family ties. Deference to community leaders—traditional healers, priests, elders and community leaders—regarding personal decision making is a strong tradition in some communities. Other important drivers are maintaining harmony within the family, obligations to engage in acts of charity, facing adversity with acceptance, and the importance of engaging in ritual–spiritual practices. All of these factors will be at play and have an influence on a person's experience of recovery.

Implications for practice

- Be mindful of the impacts of trauma and distress arising from racism, sexism, colonisation, genocide, torture, sexual and physical assault, poverty and natural disaster as well as the stigma and shame associated with having mental health issues. These impacts frequently last for generations.
- Specific skills are required for working with families, elders, interpreters and cultural advisers and being aware of cultural differences in verbal and non-verbal communication.

Implications for service delivery

- Service environments should make people feel safe. They should support healing and recovery.
- General practitioners are often the first, and sometimes the only, point of contact for some immigrants and refugees, because the stigma and shame they feel about mental illness may prevent them from using specialist mental health services. Recovery-oriented mental health services can support general practitioners in their role.
- Ida (2007) emphasises the importance of integrating primary health, mental health and drug and alcohol services while simultaneously helping people to reclaim their culture and community as part of their recovery.

Lesbian, gay, bisexual, transgender and intersex people

Many lesbian, gay, bisexual, transgender and intersex people are adversely affected by multilayered discrimination, marginalisation and stigma. Risk factors for their mental health include violence, bullying or rejection and discrimination from school, family, friends, and workplaces and from society more generally. Risk factors for intersex people can also include rejection and harassment, being forced to conform to gender norms, or pain and scarring from childhood genital surgeries or forced hormone use (Haas et al. 2011).

Lesbian, gay, bisexual, transgender and intersex people are helped in their recovery by their families, by educational institutions and workplaces, by their friends and partners, and by mainstream services and community-specific support and community groups. Mental health services that are culturally competent can also be instrumental in assisting recovery (National LGBTI Health Alliance 2012).

In demonstrating considerable resilience lesbian, gay, bisexual, transgender and intersex people share a similar narrative with people who have experienced mental health issues, particularly in how they have overcome self-stigma arising from identity issues, loss of self-esteem and discrimination.

Implications for practice

- The recovery concepts of self-determination, self-management, personal growth, empowerment, choice and meaningful social engagement are consistent with affirmative practice and with the processes of coming out.

Implications for service delivery

- It is important to ensure that lesbian, gay, bisexual, transgender and intersex people do not feel marginalised within mainstream service delivery—either from service providers or from other consumers. It is essential that peer support programs are inclusive and safe, and welcome all to participate.

Resources

Supporting LGBT lives: a study of the mental health and well-being of lesbian, gay, bisexual and transgender people (Maycock 2009).

Gender

People's life experiences and circumstances are shaped by socially constructed roles, responsibilities, identities and expectations assigned to men and to women within and across cultures (Women's Centre for Health Matters 2009, p. 2). Systemic disadvantage and barriers to health care can arise from gender roles, stereotyping and discrimination.

Implications for practice and service delivery

- Be sensitive to gender and impacts of gender constructs.
- Be alert to systemic disadvantage and barriers to services arising from gender roles, stereotyping and discrimination.

Infants, children and families

Early relationships and the early years of development (prenatal and the first three years) are critical determinants of a child's capacity for resilience, learning, health and wellbeing throughout life. The mental health and wellbeing of infants and children is closely connected to stages of growth and development—cognition, emotional regulation, language, play and social relationships (Centre for Community Child Health 2012).

Implications for practice

- Parenting competence is an important concept in recovery processes. Research indicates that the routine addition of parenting support has the potential to greatly enhance recovery-focused practice (Reupert & Maybery 2010).
- Siblings, extended family members and kin of all ages can contribute to the child's recovery process.

Implications for service delivery

- Recovery-oriented approaches with infants and children draw on perspectives of growth, health and wellbeing related to development, resilience and family systems.
- Recovery-oriented practice and service delivery with infants and children occur in collaboration and partnership with a wide range of services.⁶
- Support programs for children, siblings and parents in families experiencing mental health issues, while assisting recovery, also offer important prevention and early intervention strategies for enhancing the wellbeing of individuals and families.

Resources

Underlying principles for the right of children and young people to be nurtured by their parents and family are outlined under Principle 5 of the *Charter on the rights of children and young people in healthcare services in Australia* (Children's Healthcare Australasia 2010).

... parenting functioning is intimately related to the recovery process and functioning in other major life domains ... Nicholson (2010) found that children often give parents the strength and will to 'keep going' thereby promoting hope (a key element of recovery). Additionally, 'being a parent' and effectively assuming the parenting role, provides parents with meaning and purpose (another element of recovery). Parenting may also contribute positively to parents' lives in the community by providing opportunities for meaningful interactions and activities with others. Thus, identifying and supporting an individual's parenting role can provide hope, a sense of agency, self-determination and meaning, all consistent with a recovery approach.

Reupert & Maybery (2010)

Adolescents, young people and emerging adults

Recovery approaches with adolescents and young people are focused on prevention, early intervention, building resilience and enhancing wellbeing. They also support transition through developmental phases and where necessary, a return to expected developmental trajectories.

Young people risk identifying strongly with an illness identity at a time when they are discovering and shaping their sense of self. How and where young people seek help for mental health issues—and the services they are prepared to use—changes as they mature (Rickwood D, 2006). The transition to adult mental health services can be stressful.

6 General practitioners, prenatal and perinatal, women's health, paediatricians, community child and infant health nurses, speech therapists, early parenting and family support, men's health, support and mentoring programs, drug and alcohol services, housing, disability services, migrant resource centres, employment services, neighbourhood centres, recreational, sporting and fitness clubs, cultural associations and groups, playgroups, preschools and day care centres, schools and relevant government-based services.

Implications for practice

- Support young people to:
 - maximise learning opportunities as they increasingly assume control over decision making
 - connect with their inherent resilience, capacities and possibilities for the future
 - transition through developmental phases and, where necessary, to return to expected developmental trajectories.
- Encourage young people in:
 - positive health behaviours that promote mental health
 - early help-seeking behaviour.

Implications for service delivery

- Services should comprise a comprehensive mix of clinical and support services linked with services for younger age groups and spanning across adolescence and emerging adulthood.⁷ A primary focus is on family and peer relationships and education and vocational needs.
- An integrated approach across mental health and allied service systems⁸ is required to provide flexible and individually tailored connections between child, adolescent, and adult-focused services, both hospital-based and in the community.
- Service responses are coordinated with other youth agencies and other specialist mental health services to ensure continuity of care across the service system and during developmental transition points. A 'no wrong door' approach is emphasised and maintained. Headspace and early psychosis prevention and intervention services are recent service developments that are based on these principles.
- Mechanisms for joint planning, developing and coordinating services include young people in ways that match their developing maturity.

Older people

Older people may have a persistent or recurring mental illness, may have experienced a more recent issue as the result of bereavement, physical illness or injury (Daley et al. 2012), or be suffering from dementia or other degenerative neurological conditions. Social isolation becomes particularly acute as a person ages.

Older people have particular developmental needs, including the need to look back on life and feel a sense of fulfilment, increased interdependence between their personal and close relationships, and changing patterns of worry as people worry less about self, more about others and more about health care (McKay et al. 2012).

For older adults who have experienced a lifetime of mental health issues, the notion of recovery—its underpinning concepts, expectations and practice emphasis—can be alarming or challenging. Many deeply fear admission to an aged care facility, viewing this as 'reinstitutionalisation' (McKay et al. 2012).

7 Services provided include vocational counselling, illness management skills, training in stigma countering and disclosure strategies and context-specific social, personal and relationship skills (Rickwood D, 2006; Lloyd & Waghorn 2007). Also important are approaches that focus on physical activity as a vehicle to addressing emotional and psychological issues: sport, fitness, exercise, adventure training, art, dance, drama, music and other performing arts and recreational activities. These approaches might be provided through partnerships with community organisations, clubs and groups.

8 Primary health, mental health, alcohol and drug services, education, employment and training, parental support, recreation, physical activity, art and performing arts and community support services.

Implications for practice

- Early engagement is important so that practitioners and services understand a person's values, expectations, preferences and life choices and can act according to their wishes at times when their capacity for decision making is impaired.

Implications for service delivery

- Older people need support to connect with each other as well as with others in the community. Other priorities include:
 - establishing partnerships among mental health services, general practitioners, community nursing, aged care services, accommodation and residential facilities, disability support, Home and Community Care and other community support services
 - supporting aged care facilities and services to become more responsive and relevant to the needs of people with mental health issues
 - supporting spouses or partners, family members and close friends who may be elderly and frail themselves
 - providing opportunities for recreation, physical activity and fitness
 - responding to the increasing cultural and linguistic diversity of Australia's older population (Daley et al. 2012; McKay et al. 2012).
- Services should develop tailored recovery-oriented approaches for older people who:
 - have Aboriginal and Torres Strait Islander background
 - are living in boarding houses or unstable housing
 - are living in rural and remote communities
 - are in or are exiting prison.

Rural and remote communities

Service delivery in rural and remote communities is challenged by issues related to distance, isolation and fewer formal services, higher levels of stigma associated with mental health issues and stoicism that influences people's help-seeking behaviours (Rickwood D, 2006).

Implications for service delivery

- Services should foster partnerships that increase local access to primary health care, specialist physical health care, allied health care, psychosocial rehabilitation and recovery support.
- Non-health services, community groups, local leaders and naturally occurring support networks are vital recovery partners in rural and remote communities, as are schools, churches, the police, local businesses and clubs. Servicing more remote communities with fewer formal services will require broader collaboration.
- Tailored responses will be required to particular groups in rural and remote communities, including:
 - older people, many of whom experience high levels of disadvantage
 - Aboriginal and Torres Strait Islander people (whose populations are frequently younger than the Australian average)
 - fly-in/fly-out workers and communities, many of whom experience high levels of isolation
 - people from immigrant and refugee backgrounds who may feel isolated due to absent family or a lack of ethnospecific community networks.

- Services should give priority to:
 - increasing awareness, understanding and acceptance of mental illness, increasing help-seeking behaviours and supporting communities to develop their capacity to assist people with mental health issues and their families
 - using information and communications technologies to overcome issues of distance, isolation, lack of services, lack of peer support and limited opportunities for professional support and development
 - facilitating affordable options for those wishing to access mental health care away from their local communities.

People with coexisting conditions and complex care needs

Experiencing coexisting conditions is normal for people, not exceptional (Graham & White 2011). Rates of mental illness are high for people with intellectual disability, autism spectrum disorders, alcohol and drug use, physical disability, brain injury, problematic gambling, and those who are experiencing homelessness. Multiple physical health problems are also commonly present.⁹ Yet many people with high and complex needs remain undiagnosed and not effectively connected to mental health services. General practitioners and community health centres play a key role in recovery for people with coexisting conditions by offering medical advice and help for physical and mental health needs (including substance use).

The experience of coexisting conditions frequently goes hand in hand with socioeconomic hardships, isolation and a lack of personal, family and social support at key transition points.

Implications for practice

- Share information with people and their families and friends about self-help and peer support groups that are relevant to their needs and circumstances.
- In the absence of family or other natural supports for advocacy, psychiatric advance directives can assist people with complex needs to have some control over what happens to them when they become unwell.
- Form close relationships and share information with other practitioners and services to respond to events and ensure that people's recovery goals coalesce and complement each other to form an integrated support and wellbeing plan.
- Assist people to gain maximum benefit from the services and programs they offer.
- Support people to reconnect with family and close friends as well as to build new personal relationships and support networks (Graham & White 2011).

Implications for service delivery

- Services should be responsive irrespective of a person's entry point and should not prioritise the needs arising from one condition over another.
- Responses should be multidisciplinary and include primary health care and specialist health services.
- Understanding of recovery paradigms used in other fields—for example, in the alcohol and drug sector (Best 2012)—need to be incorporated into jurisdictional-wide and local guidelines for working with people and families with coexisting conditions.
- Services should take the lead in challenging stigma, myths and stereotypes and low expectations about particular groups with coexisting conditions.

⁹ The experience of coexisting conditions commonly involves multiple health problems, especially physical health issues—heart disease, diabetes, hepatitis C, liver issues, oral health, skin conditions, effects of poor nutrition and effects of musculoskeletal and orthopaedic conditions.

... I'm born with an ABI mild Brain Damage and profound disability... plus I'm borderline Autistic too ... Bigger ... Ya! ... Where there's a will there's a way ... that's what I keep saying to myself ... I've done a lot of things on my own with little to no help. I've been going to workshops and conferences on my own to help me in my hidden Intellectual Disability World that I was born into ... being labelled both ways doesn't help but its who I am and I am tapping into funding when I can YA! I just do the best I can each day ... I am growing.

Participant in the framework consultations

People with unresolved trauma issues

- **The possibility of trauma in the lives of people accessing services should be a central organising principle of care, practice and service provision. Many people who have experienced trauma have adopted extreme coping strategies in order to manage the impacts of overwhelming traumatic stress, including suicidality, substance use and addictions, self-harming behaviours such as cutting and burning, dissociation, and re-enactments such as abusive relationships. Although awareness and treatment of trauma may be pivotal to the process of recovery, in many mental health settings trauma is seldom fully identified or addressed.**

Implications for practice and service delivery

A trauma-informed recovery-oriented service:

- **commits to and acts upon the core organising principles of safety, trustworthiness, choice, collaboration and empowerment**
- **considers and evaluates all parts of the system in the light of a basic understanding of the role that violence and abuse play in the lives of people seeking mental health and drug and alcohol services**
- **applies this understanding to the design of service systems that accommodate the vulnerabilities of trauma survivors, that deliver services in a way that avoids retraumatising people and facilitates people's participation in their treatment**
- **trains staff in trauma-informed care and practice**
- **develops collaborative relationships with practitioners experienced in traumatology wherever possible (Fallot & Harris 2009).**

Trauma survivors still experience stigma and discrimination and unempathetic systems of care. Clinicians and mental health workers need to be well informed about current understanding of trauma and trauma-informed interventions.

Professor Louise Newman in *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery* (Kezelman & Stavropoulos 2012).

People in the criminal justice and youth justice systems

Many mental health services working within Australian criminal justice, youth justice and forensic systems have in recent times implemented recovery-oriented approaches. They face many challenges operating in environments that limit liberty and autonomy and enforce obligations for legal accountability and treatment compliance.

Providing services in settings controlled by other authorities

Mental health services operating in courts, correctional facilities, community correctional settings, juvenile justice facilities and community-based programs and probation and parole programs do not have administrative control over the settings and programs in which they operate. The recovery aspirations, goals and plans of a person in the criminal justice, youth justice and forensic settings can be contrary to the responsibilities of the mental health service to maintain security and manage risk. Implementing recovery-oriented approaches in these settings involves considerable and persistent cross-agency negotiation and collaboration as well as open and transparent communication with the people who are in their services.

Understanding and navigating complex layers of coercion

People in facility- or community-based institutional settings are frequently not motivated to engage in treatment because their mental health assessment, treatment or placement was ordered by courts or correctional authorities. People deprived of their liberty frequently view such orders as double jeopardy and fear that forensic patient status might delay their return to the community. Complex layers of coercion within these settings, and the obligation of practitioners to satisfy certain requirements (such as reporting) affect a person's willingness to accept a therapeutic relationship or mental health services. Transparency and open discussion of legal responsibilities are critical while practitioners actively seek opportunities to support people's exercise of choice, self-management of risk and access to opportunities for learning, growth and development.

Strengths-based practice models are useful in embedding recovery practice in institutional settings. Wellness recovery action plans or similar recovery tools are also helpful.

Working with people who have experienced considerable adversity

Recovery-oriented practice and service delivery acknowledges that many people in criminal justice, youth justice and forensic settings have experienced considerable social disadvantage and childhood adversity and trauma. Many have been in some form of care for significant periods. Their health is often poorer than other people with mental health issues. They may suffer from intellectual disability, acquired brain injury, alcohol and drug use and physical disabilities. Their involvement in the criminal justice system may compound an already poor sense of self-worth and efficacy. Responses need to be multidisciplinary, multiagency, cross-sectoral, and collaborative. Services need to reach out to the community and provide opportunities for community services to reach in.

Recovery approaches in criminal justice settings employ rehabilitation and throughcare¹⁰ models that support progressive recovery and focus on life skills, meaningful activity, education and vocational training and increased reconnection with the community (Simpson & Penney 2011). People are supported to reclaim control to the extent possible in the circumstances (Kaliski & de Clercq 2012). Follow-up is particularly important to ensure that recovery gains are not lost when a person returns to the general prison population upon discharge from forensic mental health facilities.

Incarceration adds to the isolation experienced by those who have already faced prolonged disconnection from their families (Dorkins & Adshead 2011). Recovery approaches support reconnection and the building of healthy relationships with family and friends.

Supporting people to reclaim meaning

Recovery-oriented practice supports people in custodial settings to reclaim meaning and to build new identities. This includes:

- incorporating aspects of their former lives and acknowledging the events that led to their incarceration
- understanding the impact of their actions on their own lives and on the lives of others (Dorkins & Adshead 2011)
- managing their personal potential for risk.

In supporting people to rebuild their identity, recovery approaches create opportunities for peer support (Simpson & Penney 2011). The sharing of personal stories promotes hope and helps to reduce shame and isolation.

Supporting the recovery of people who are detained for long periods

Some people will reside in maximum-security facilities for long periods, some indefinitely. Recovery-oriented practice and service delivery in criminal justice and forensic settings offers a means of optimising the lives of these people (Kaliski & de Clercq 2012). Practitioners seek to engage them in optimistic and hopeful discussion about their mental health issues, and their views on treatment and support. They seek to increase people's self-esteem and create opportunities for building life skills, by enabling a better use of time, and by offering hope for eventual return to the community, a place to call home, autonomy, skills, a job, family and friends.

¹⁰ Throughcare is the coordinated, integrated and collaborative delivery of programs and services to offenders to reduce the risks of reoffending and enable successful integration into the community. Services are provided both during incarceration and after release (NSW Department of Corrective Services 2008; ACT Corrective Services 2010; Borzycki & Baldry 2003).

11 Conclusion

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

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

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

Appendix—Capabilities in detail

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

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

Core principles	<ul style="list-style-type: none"> • Language matters • Services can make a significant contribution to and actively encourage people's recovery efforts by embedding and communicating a culture of hope, optimism, potentiality, choice and self-determination • All staff can contribute to recovery outcomes by offering respectful, person-centred relationships, practices and service environments that inspire hope and optimism
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> • respect and value a person's inherent worth and importance • affirm a belief in a person's capacity to recover, thrive and lead a meaningful and contributing life • celebrate a person's recovery effort, perseverance and achievements • value the role of peers in creating optimistic and hopeful culture and language • commit to embedding positive change in language and practice
Knowledge	<ul style="list-style-type: none"> • understand the philosophical underpinnings of recovery and its origin in the consumer movement • maintain knowledge of current issues in recovery literature and research, including from broader fields like positive psychology, the human potential movement and organisational culture change • learn from research undertaken by people with lived experience of mental health issues
Skills and behaviours	<ul style="list-style-type: none"> • encourage a culture of hope by communicating positive expectations and messages about recovery • encourage a culture of hope through the use of optimistic language in interactions, in forms, records, policies, correspondence and brochures • reorient language, systems and processes to reflect and encourage positive outcomes • promote implementation of trauma-informed practice principles in all interactions (Guarino et al. 2009) • model the use of optimistic language among staff members • reframe setbacks in the context of longer term recovery outcomes and positive learning opportunities • share research with people who experience mental health issues and their families and support people
Recovery-oriented practice	<ul style="list-style-type: none"> • celebrate and promote people's recovery stories and successes • reflect and encourage strengths and positive outcomes rather than deficits • acknowledge progress and reframe setbacks using affirmative language • note and remind people of indicators of progress towards recovery goals • invite people to discuss what they want recorded about their lives and the services received • model positive and supporting behaviours among service staff and practitioners as an important adjunct to supporting people's recovery • encourage learnt optimism and positive expectations

Capability 1A: The culture and language of a recovery-oriented mental health service communicates positive expectations, promotes hope and optimism and results in a person feeling valued, important, welcome and safe.	
Recovery-oriented leadership	<ul style="list-style-type: none"> • model recovery-oriented behaviours and language in service planning, coordination and review processes • affirm the importance of creating opportunities for people to gather and share their lived experience and stories of recovery • celebrate achievements, growth and progress towards recovery goals and objectives • provide organisational support for people to advocate for themselves • lead and promote the commitment to active collaboration with lived experience in all aspects of service • initiate conversations about how to build a hopeful and optimistic organisation that communicates positive expectations.
Opportunities	
<ul style="list-style-type: none"> • Establish e-kiosks for service-wide exchange of knowledge and information about recovery concepts to ensure a critical mass of informed consumers, peers, staff and family members. • Support the development of peer-produced resources that share and celebrate recovery stories and make these available to people with a lived experience, their family members and friends through media such as films, booklets, film and art galleries, newspapers, social media, recovery blogs and so on. • Identify and support local recovery champions. • Promote positive health resources. 	
Resource materials	
<ul style="list-style-type: none"> • Our Consumer Place, www.ourconsumerplace.com.au/resources • Victorian Department of Health 2011, <i>Framework for recovery-oriented practice</i>, docs.health.vic.gov.au/docs/doc/0D4B06DF135B90E0CA2578E900256566/\$FILE/framework-recovery-oriented-practice.pdf • Williams et al. 2012, 'Measures of the recovery orientation of mental health services: systematic review', <i>Social Psychiatry and Psychiatric Epidemiology</i>, Advanced Online publication, DOI 10.1007/s00127-012-0484-y 	

Domain 2: Person 1st and holistic

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

Recovery-oriented mental health practice and service delivery acknowledges the range of influences that affect a person's mental health and wellbeing and provides a range of treatment, rehabilitation, psycho-social and recovery support.

<p>Core principles</p>	<ul style="list-style-type: none"> • In acknowledging and accepting the centrality of people with lived experience in their own recovery, mental health services seek to create environments enabling people to direct their own lives and meet the needs they have identified. • Mental health care acknowledges and is tailored to people's preferences, life circumstances and aspirations, and to their family and personal supports. • Mental health services recognise and account for the multiple elements that affect individuals' wellbeing including personal beliefs, cultural background, values, social and family contexts, physical health, housing, education and employment.
<p>Characteristics</p>	<p>Mental health practitioners and providers...</p>
<p>Values and attitudes</p>	<ul style="list-style-type: none"> • believe in the ability and right of a person to make their own life decisions • respectfully explore a person's circumstances, what is important to them, and their aspirations for recovery and wellbeing • view people in the context of their whole selves and lives and view their personal recovery as the primary process of working towards wellness • respect and uphold people's complex needs and aspirations across cultural, spiritual, relationship, emotional, physical, social and economic realms—not just in relation to their illness or mental health issues • demonstrate kindness, honesty and empathy in their interactions with people
<p>Knowledge</p>	<ul style="list-style-type: none"> • understand the individual nature of personal recovery • incorporate bio-psychosocial theoretical perspectives of health, mental health and wellbeing • understand the interplay between physical health, mental health, disability and coexisting conditions and the importance of collaboration to address needs simultaneously • understand a range of personal recovery approaches including those developed by people with lived experience of mental health issues • know major types of treatments and therapies and their possible contributions to a person's recovery including biological and pharmacological treatments, psychological and psychotherapeutic approaches, psychosocial rehabilitation and support, physical health care, physical activity and exercise interventions, alcohol and drug treatment and counselling, traditional healing in different cultures and alternative and complementary treatments • understand the high prevalence of trauma experienced by people with a lived experience, how to assist a person affected by trauma and how to prevent the retriggering of trauma
<p>Skills and behaviours</p>	<ul style="list-style-type: none"> • facilitate access to information, treatment, support and resources that contribute to a person's recovery goals and aspirations • acknowledge a person's family, carers and personal supports • Promote people's self-advocacy to meet their identified needs and recovery goals • articulate the pros and cons of different treatment to promote decision making and to support people to make the best use of treatments and therapies, minimise side effects, achieve an optimal, therapeutic level of medication and to withdraw from medication where appropriate • coordinate and collaborate with a range of relevant services beyond the mental health system including health services, alcohol and drug services, disability services, employment, education, training services and housing services

Capability 2A: Holistic and person-centred treatment, care, rehabilitation and psychosocial and other recovery support	
Recovery-oriented practice	<ul style="list-style-type: none"> • shape service responses to match people's aspirations, expectations, goals and needs • investigate the potential for alternative responses to those offered by the service • demonstrate trauma-informed practice • create opportunities for improvement in physical health, exercise, recreation, nutrition, expressions of spirituality, creative outlets and stress management • learn from and are informed by a person's understanding of what helps • maintain connections with referring agencies and explore new service partnerships
Recovery-oriented leadership	<ul style="list-style-type: none"> • encourage flexibility in supporting people's recovery goals • ensure holistic assessment processes that include reference to a person's home environment, personal goals, priorities and relationships • have clinical governance and professional development processes in place to ensure that the person is central to all that is done • review procedures and service environments to ensure that they are accessible (disability and age-appropriate, access and signage) • ensure that best-practice processes for coordination and collaboration are in place (referral pathways, service conferencing, shared care and joint discharge planning).
Opportunities	
<ul style="list-style-type: none"> • Ensure that staff, consumers and families have access to information and narratives about recovery in different formats and mediums. 	
Resource materials	
<ul style="list-style-type: none"> • Glover, <i>Unpacking practices that support personal efforts of recovery: a resource book written for the workers and practitioners within the mental health sector</i> • Scottish Recovery Network, <i>Module 4: providing person-centred support</i>, Realising recovery, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html • Kezelman & Stavropoulos 2012, <i>Practice guidelines for treatment of complex trauma and trauma informed care and service delivery</i>, Adults Surviving Child Abuse, Sydney • Queensland Health 2010, <i>Dual diagnosis clinical guidelines and clinicians' toolkit</i>, www.dualdiagnosis.org.au/home/index.php?option=com_contentandtask=viewandid=72andItemid=1 	

Domain 2: Person 1st and holistic

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

Recovery-oriented practice and service delivery with Aboriginal and Torres Strait Islander people must recognise the resilience, strengths and creativity of Aboriginal and Torres Strait Islander people, understand Indigenous cultural perspectives, acknowledge collective experiences of racism and disempowerment, and understand the legacy of colonisation and policies that separated people from their families, culture, language and land.

Core principles	<ul style="list-style-type: none"> The nine principles in the <i>National strategic framework for Aboriginal and Torres Strait Islander people's mental health and social and emotional wellbeing 2004–09</i> are a starting point www.health.gov.au/internet/main/publishing.nsf/content/8E8CE65B4FD36C6DCA25722B008342B9/\$File/wellbeing.pdf. In building the cultural competence and capacity of practitioners and services it is important to seek guidance and advice from Aboriginal and Torres Strait Islander Elders, leaders, mental health practitioners, advisers and members of the Stolen Generations.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> actively challenge personal attitudes and behaviours that may inadvertently support racism and discrimination of Aboriginal and Torres Strait Islander people increase their personal understanding of the culture and traditions of Aboriginal and Torres Strait Islander people value the special expertise and understanding of mental health issues that are available within Aboriginal and Torres Strait Islander communities, especially from Elders, traditional healers, Indigenous health and mental health workers, cultural advisers and members of the Stolen Generations learn from Aboriginal and Torres Strait Islander people about creating and improving models include Aboriginal and Torres Strait Islander people and community representatives in decision making
Knowledge	<ul style="list-style-type: none"> understand the importance of land, spirituality and culture to the mental health of Aboriginal and Torres Strait Islander people understand the impact mainstream Australian community attitudes and policies have had and continue to have on Aboriginal and Torres Strait Islander people recognise the connection between serious general health problems and social, emotional and psychiatric difficulties (including substance use), many of which are untreated or inappropriately treated in Aboriginal and Torres Strait Islander communities recognise that working with Aboriginal and Torres Strait Islander people may require specific expertise and understanding, for example, understanding of cultural traditions as they affect verbal and non-verbal communication have knowledge and appreciation of the contribution of traditional healing practices to the recovery of Aboriginal and Torres Strait Islander people
Skills and behaviours	<ul style="list-style-type: none"> support personal recovery efforts by affirming the resilience, strengths, creativity and endurance of Aboriginal and Torres Strait Islander people provide service environments that reduce anxiety for Aboriginal and Torres Strait Islander people and assist with engagement actively acknowledge the value systems and protocols which exist in Aboriginal and Torres Strait Islander communities draw on and use Indigenous understandings of and approaches to social and emotional wellbeing and healing collaborate with cultural and traditional ways of healing in partnership with mainstream therapies understand that it may neither be appropriate nor desirable to apply ethical and clinical models derived from a western individualistic viewpoint when working with Aboriginal and Torres Strait Islander individuals and communities, and demonstrate flexibility in modifying or not using certain aspects of such models demonstrate reflective practice by acknowledging the possible impacts on Aboriginal and Torres Strait Islander people of the values, biases and beliefs built into professional training and service systems

Capability 2B: Responsive to Aboriginal and Torres Strait Islander people, families and communities	
Recovery-oriented practice	<ul style="list-style-type: none"> • make every effort to ensure that language does not present a barrier • seek out Aboriginal and Torres Strait Islander expertise and advice concerning service requirements arising from gender, age and other cultural contexts • work with families and kinship networks, ensuring access to services across the life span including prenatal, perinatal, early childhood, early learning and early intervention programs • support communities with their self-identified priorities, for example, access to early intervention and support for children showing signs of foetal alcohol syndrome • use technology to facilitate communication with and participation by extended family and kinship networks • recognise that professional practice in this area can involve challenging government policy and community attitudes that impact negatively on Aboriginal and Torres Strait Islander people's social, emotional, cultural and spiritual wellbeing • use information about Aboriginal and Torres Strait Islander services, programs and groups in a strengths-based approach throughout a person's contact with the service
Recovery-oriented leadership	<ul style="list-style-type: none"> • recruit and support Aboriginal and Torres Strait Islander people throughout the organisation including in positions of leadership, direct practice, peer-support, policy, research, training, education and administration • partner with Aboriginal and Torres Strait Islander people, communities, organisations and groups to design culturally appropriate and safe spaces within facilities • develop flexible multidisciplinary, multiagency and cross-sectoral responses that span the geographic boundaries of service systems • with local Aboriginal and Torres Strait Islander people, develop resources that welcome a person to country and walk a person through what to expect and how the service operates • actively support local Aboriginal and Torres Strait Islander community efforts to improve mental health and social and emotional wellbeing • use existing cross-cultural and cultural competency training resources.
Opportunities	
<ul style="list-style-type: none"> • Develop a service-based reconciliation action plan. • Make an organisational commitment to provide training, employment and leadership opportunities for Aboriginal and Torres Strait Islander people. • Participate in cultural events like NAIDOC Week (National Aborigines and Islanders Day Observance Committee), Reconciliation Week and National Sorry Day. 	
Resource materials	
<ul style="list-style-type: none"> • Purdie, Dudgeon & Walker 2012, <i>Working together: Aboriginal and Torres Strait Islander mental health and wellbeing practice and principles</i>, www.healthinfonet.ecu.edu.au/key-resources/promotion-resources?lid=17709 • RANZCP 2009, <i>Ethical guideline 11: principles and guidelines for Aboriginal and Torres Strait Islander mental health</i>, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Ethical_Guidelines/eg11-pdf.aspx • RANZCP 2011, <i>Position statement 42: Stolen Generations</i>, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps42-pdf.aspx • Australian Psychological Society 1995, <i>Guidelines for the provision of psychological services for and the conduct of psychological research with Aboriginal and Torres Strait Islander people of Australia</i>, depressionet.com.au/dres/aboriginal_people.pdf 	

Domain 2: Person 1st and holistic

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

Recovery-oriented mental health practice and service delivery addresses barriers to services encountered by people from immigrant and refugee backgrounds including people seeking asylum.

Core principles	<ul style="list-style-type: none"> Recovery is a collection of processes that occur within a web of relations including the individual, family and community and is contextualised by culture, language, oppression and privilege, history and the social determinants of health. Responsiveness to people from immigrant and refugee backgrounds requires organisational capacity at different levels: systemic, organisational and practice. Recognising the diverse ways in which the concepts of mental health, mental illness and recovery may be understood by people from immigrant and refugee backgrounds requires an awareness of the impact of the practitioner's own ethnocultural identity, as well as that of the organisation and service system.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> demonstrate compassion and respect for people from immigrant and refugee backgrounds reflect on their own identities and relationship to people from immigrant and refugee backgrounds reflect on their own assumptions about people from immigrant and refugee backgrounds demonstrate openness to other people's perspectives of mental health, illness and recovery
Knowledge	<ul style="list-style-type: none"> have knowledge of local immigrant and refugee communities understand the possible impacts of migration or of seeking refuge are alert to cultural differences in idioms of distress, symptom presentation and explanatory models of health and illness are mindful that racism, access barriers and other social factors can increase health disparities and impede people from immigrant and refugee backgrounds from knowing and exercising their rights know community organisations and resources that support people from immigrant and refugee backgrounds
Skills and behaviours	<ul style="list-style-type: none"> actively explore how people and their families from immigrant and refugee backgrounds understand mental health, illness and recovery work effectively with interpreters, cultural brokers as well as immigrant and refugee settlement workers, bilingual community workers, and faith leaders to support a person's recovery plans provide people and their families with the information they need to make decisions about their mental health care including written information in easy to read English or in community languages and/or explained via an interpreter support people from immigrant and refugee backgrounds to know and exercise their human rights and legal rights respond to the additional needs of people and families from refugee backgrounds
Recovery-oriented practice	<ul style="list-style-type: none"> apply culturally responsive practice to all consumers, not just those from immigrant and refugee backgrounds respect and respond to people's cultural and religious beliefs and faith traditions engage with people in the context of their families and important relationships and, where appropriate, other members of their community involve and support family members and other significant people

Capability 2C: Responsive to people from immigrant and refugee backgrounds, their families and communities	
Recovery-oriented leadership	<ul style="list-style-type: none"> • put processes and service development initiatives in place to become an effective culturally responsive organisation including language policies, cultural diversity plans, data collection/analysis related to local populations, and working groups to champion cultural issues • establish systems to ensure practitioners work effectively with interpreters and provide appropriate translated material • provide staff with opportunities to acquire the core attitudes, knowledge and skills necessary for working effectively with immigrant and refugees • support practitioners to respect people's cultural and other human rights • recognise the time that is needed for practitioners to include families and carers • actively seek the participation of people with lived experience of mental health issues and family members and carers from immigrant and refugee backgrounds • foster particular workforce positions and roles that will address the specific needs of the local population, for example, bilingual workers, cultural liaison workers, immigrant and refugee peer workers, cultural portfolio holders or champions.
Opportunities	
<ul style="list-style-type: none"> • Develop partnerships with immigrant and refugee community organisations and ethnospecific community networks and undertake community development initiatives. • Develop a whole-of-organisation cultural responsiveness plan. • Participate in community events such as Cultural Diversity Week, Refugee Week and other festivals and celebrations. • Subscribe to multicultural organisations' e-bulletins, for example, Federation of Ethnic Community Councils and the Australian Collaboration. 	
Resource materials	
<ul style="list-style-type: none"> • <i>National cultural competency tool (NCCT) for mental health services</i> www.mhima.org.au/mental-health-information-and-resources/clinical-tools-and-resources • <i>Position paper: guidelines for training in cultural psychiatry</i>, Kirmayer et al. 2012 74.220.215.217/~blogmmhr/wp-content/uploads/2012/09/En_Training-in-Cultural-Psychiatry.pdf • Victorian Department of Health 2009, <i>Cultural responsiveness framework: guidelines for Victorian health services</i>, www.health.vic.gov.au/cald/cultural-responsiveness-framework • RANZCP 2012, <i>Position statement 46: provision of mental health services to asylum seekers and refugees</i>, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps46-pdf.aspx 	

Domain 2: Person 1st and holistic

Capability 2D: Responsive to and inclusive of gender, age, culture, spirituality and other diversity irrespective of location and setting

Recovery-oriented mental health practice and service delivery is respectful of and responsive to diversity in the community.

Core principles	<ul style="list-style-type: none"> • Effective mental health services are responsive and suited to a person's age, developmental phase and gender-related needs. • Responsive and inclusive services respect and accommodate diversity among people who use services, including people from diverse cultural backgrounds, language groups and communities. • Gender, sex identity, sexual orientation, religious beliefs and spiritual practices are acknowledged and responses to diversity become core components of service delivery. • Diverse views on mental health issues/illness, wellbeing, treatments, services and recovery are understood and accommodated. • Recovery-oriented services seek to overcome the adverse impacts of location or setting.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> • embrace, value and celebrate diversity • understand their own values, assumptions and world views • recognise peoples' expression of their personal identity and beliefs • acknowledge the relevance of personal belief systems to mental health including cultural, religious and spiritual perspectives
Knowledge	<ul style="list-style-type: none"> • understand stages of human development and how approaches to recovery might differ across the life span • understand cultural diversity and its applicability to mental health practice and service delivery • understand the range of factors influencing people's expectations of safe practice
Skills and behaviours	<ul style="list-style-type: none"> • demonstrate sensitivity when working with people and families from a diverse range of backgrounds irrespective of age, developmental phase, gender, culture, religious beliefs or language group • use the information provided by diverse groups of people about their preferences and needs to develop appropriate responses • provide safe care that reflects and actively includes people's values, aspirations, goals, circumstances and previous life choices • deliver developmentally appropriate responses • support people in the practice of spiritual activities they find helpful • understand the importance of seeking out assistance when in doubt about aspects of diversity
Recovery-oriented practice	<ul style="list-style-type: none"> • provide opportunities for people to share information about their needs and expectations related to age, development, gender, sex identity, sexual orientation and spirituality • include family recovery approaches, especially for infants, children and where relevant for adolescents • ensure access to diversity and cultural support services when required • access knowledge about diversity from people with lived experience of mental health issues • establish understanding of shared and different perspectives of mental health

Capability 2D: Responsive to and inclusive of gender, age, culture, spirituality and other diversity irrespective of location and setting	
Recovery-oriented leadership	<ul style="list-style-type: none"> • ensure participation opportunities for all, including children and young people • proactively incorporate input from people with a lived experience to ensure responsiveness to age, gender and diversity in organisational policy, practice and service improvements • set in place processes for systematically identifying training needs and regularly reviewing practices to ensure that staff and volunteers embrace cultural, gender and age sensitive and safe practice • routinely offer appropriate age, gender and diversity competence development and training • have systems in place to identify and monitor the changing needs of local population groups.
Opportunities	
<ul style="list-style-type: none"> • Use e-mental health service developments to increase responsiveness to rural and remote communities and to fly in/fly out employees, their families and their adopting communities. 	
Resource materials	
<ul style="list-style-type: none"> • Women's Centre for Health Matters 2009, <i>WCHM position paper on Gender sensitive health service delivery</i>, Women's Centre for Health Matters, Canberra, www.wchm.org.au/GenderSensitiveHealthServiceProvision.htm • Victorian Department of Health 2011, <i>Cultural responsiveness framework: guidelines for Victorian health services</i>, docs.health.vic.gov.au/docs/doc/Cultural-responsiveness-framework---Guidelines-for-Victorian-health-services • AICAFMHA 2008, <i>National youth participation strategy (NYPS) in mental health</i>, www.aicafmha.net.au/youth_participation/files/AIC35_report.pdf 	

Domain 2: Person 1st and holistic

Capability 2E: Responsive to lesbian, gay, bisexual, transgender and intersex people, their families of choice, and communities

Recovery-oriented mental health practice and service delivery recognises and affirms sexuality, sex or gender diversity.

Core principles	<ul style="list-style-type: none"> Recovery-oriented practice recognises and affirms diversity in sexuality, sex or gender. Recovery-oriented practice recognises the negative impact of discrimination, stigma and phobia on the wellbeing of lesbian, gay, bisexual, transgender and intersex people. Recovery-oriented services recognise these populations as high risk and ensure safe and welcoming environments and services free from discrimination. Recovery-oriented services ensure a culturally competent and safe workforce that is knowledgeable and responsive to the lived experience of lesbian, gay, bisexual, transgender and intersex people.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> are affirming of diverse sexuality, sex or gender do not tolerate discrimination against lesbian, gay, bisexual, transgender and intersex people demonstrate empathy for the impact that stigma, discrimination and prejudice can have on these people's mental health respect intersex and other people's right to choose their own gender and, if they choose, to not conform to gender norms
Knowledge	<ul style="list-style-type: none"> know current trends in the field of service provision for lesbian, gay, bisexual, transgender and intersex people know cultures, identities, jargon and common experiences of discrimination for lesbian, gay, bisexual, transgender and intersex people understand the fear of discrimination or violence experienced by many lesbian, gay, bisexual, transgender and intersex people critically analyse dominant and normative cultural assumptions, beliefs and values about sexuality know the specific issues affecting intersex people, for example, trauma from childhood genital surgery, hormone use, being forced to conform to norms, or family secrecy know local and online community-specific support groups and organisations and practitioners who welcome lesbian, gay, bisexual, transgender and intersex people know advocacy organisations for lesbian, gay, bisexual, transgender and intersex people know the layers of stigma and discrimination experienced by lesbian, gay, bisexual, transgender and intersex people who also have a disability, are from culturally or linguistically diverse backgrounds, or identify as Aboriginal or Torres Strait Islander
Skills and behaviours	<ul style="list-style-type: none"> establish rapport with lesbian, gay, bisexual, transgender and intersex people and understand where presenting concerns are related to diverse sexuality, sex and gender use gender-neutral and inclusive language use a transgendered person's preferred pronoun advocate for and support lesbian, gay, bisexual, transgender and intersex people's self-advocacy acknowledge and make use of a person's key sources of personal support, including their partner or close friends work with consumers to prevent discrimination consult lesbian, gay, bisexual, transgender and intersex people about whether to record their diverse sexuality, sex or gender on their records, and how they would like their personal information to be recorded, used and shared

Capability 2E: Responsive to lesbian, gay, bisexual, transgender and intersex people, their families of choice, and communities	
Recovery-oriented practice	<ul style="list-style-type: none"> • demonstrate understanding of and respect for people of diverse sexuality, sex or gender and their carers • provide a welcoming environment in waiting rooms, for example, display rainbow stickers, service pamphlets and posters affirming diversity • form partnerships with organisations and services that are targeted specifically to lesbian, gay, bisexual, transgender and intersex people • include appropriate options on forms such as intake, incident and feedback forms • ensure organisational promotional material is welcoming of lesbian, gay, bisexual, transgender and intersex people and provides accurate information on the mental health risks they experience • seek out and embrace training in cultural competency
Recovery-oriented leadership	<ul style="list-style-type: none"> • proactively incorporate responsiveness to the lived experience of lesbian, gay, bisexual, transgender and intersex people in organisational policy and practice • use research and evidence to support staff to improve practice, service delivery and outcomes for lesbian, gay, bisexual, transgender and intersex people and their partners and families • analyse their performance in working with lesbian, gay, bisexual, transgender and intersex people as part of an ongoing assessment of their experiences • collect information about diverse sexuality, sex and gender if it is directly related to, and reasonably necessary for, responsiveness • have systems in place for the ongoing identification and monitoring of the changing needs of consumers • demonstrate leadership in promoting acceptance of sexual diversity, and implement mechanisms to redress discrimination • routinely offer appropriate diverse sexuality, sex and gender competence development and training for staff and volunteers.
Opportunities	
<ul style="list-style-type: none"> • Establish and promote links with community-specific support groups and organisations and practitioners who welcome lesbian, gay, bisexual, transgender and intersex people. • Undertake the Rainbow Tick process: an accreditation process for inclusive practice with lesbian, gay, bisexual, transgender and intersex people in Australia www.glhv.org.au/glbti-inclusive-practice. 	
Resource materials	
<ul style="list-style-type: none"> • Victorian Department of Health 2011, <i>Well proud: a guide to GLBTI inclusive practice for health and human services</i>, www.glhv.org.au/health-service-audit/well-proud-guide-glbti-inclusive-practice-health-and-human-services • National LGBTI Health Alliance 2012, <i>Pathways to inclusion: frameworks to include LGBTI people in mental health and suicide prevention services and organisations</i>, www.lgbthealth.org.au/sites/default/files/Pathways%20to%20Inclusion%20May%202012v5.pdf • Gay and Lesbian Health Victoria, <i>Sexual diversity health service audit</i>, www.glhv.org.au/sexual-diversity-health-services-audit 	

Domain 2: Person 1st and holistic

Capability 2F: Responsive to families, carers and support people

Recovery-oriented practice and service delivery recognises the unique role of personal and family relationships in promoting wellbeing, providing care, and fostering recovery across the life span, and recognises the needs of families and support givers themselves.

Core principles	<ul style="list-style-type: none"> • A person's ability to fulfil their roles and responsibilities within significant relationships can promote and sustain personal recovery efforts; a person's parenting roles and responsibilities are particularly important. • The important roles played by family members, carers, peers and significant others is acknowledged and supported in contributing to the wellbeing of people experiencing mental health issues. • Families, carers, significant others and peers are viewed as partners. • Mental health practitioners and services acknowledge and are responsive to the needs of families, friends and other carers for information, education, guidance and support for their own needs as well as to enable them to assist a person's recovery. • Choices about the involvement in personal recovery of family and significant others rests with the person living with mental health issues, with due consideration for what is age appropriate.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> • recognise, value and affirm the importance of a person's roles and responsibilities within their personal relationships • recognise, value and respect the role of family members, carers and significant others • understand and empathise with the journeys of recovery, healing, wellbeing, growth and learning that families are undertaking • understand, respect and respond to family diversity • are sensitive and responsive to children and young people in families experiencing mental health issues
Knowledge	<ul style="list-style-type: none"> • understand the impact of mental health issues on close relationships • understand and respect the tensions inherent in balancing the wishes and personal recovery aspirations and goals of people and those of their family and carers, including tensions about privacy and personal information • recognise the diversity of family relationships and responsibilities, including but not limited to different cultures, same-sex relationships and blended families • understand the needs of families and have up-to-date knowledge of services and supports available to meet those needs
Skills and behaviours	<ul style="list-style-type: none"> • provide people with opportunities to identify and express relationship support choices and needs • assist people to maintain, establish or re-establish relationships with family and support people • support people to fulfil important roles such as parenting • assist family members and significant others to feel safe, welcome and valued • help families to support the recovery of a relative • help families to identify and meet their own support needs, for example support with their own responses, information needs, and support/education to use a recovery approach • as soon as possible, offer family and people in a person's support network assistance to navigate service systems • advocate and support self-advocacy for family members and carers when interruption to their education, training, or employment leads to economic and social hardships • seek out and incorporate the views of families and carers in practice and service delivery

Capability 2F: Responsive to families, carers and support people	
Recovery-oriented practice	<ul style="list-style-type: none"> • are vigilant in identifying and meeting the support needs of children and young people in families experiencing mental health issues • are clear about rights and responsibilities in relation to privacy and consent, including with respect to family member involvement, and encourage open discussion when views and interests are in conflict • encourage and support people when they are well to develop advanced care directives or plans for the care of their children • support people in sharing key elements of recovery goals and approaches with family and support people
Recovery-oriented leadership	<ul style="list-style-type: none"> • review organisational policy and procedures to ensure that they embrace working collaboratively with families, carers and support networks • offer flexibility in working with families, carers and support people, including opportunities for off-site, out-of-hours and in-home assessment and service • promote family and carer peer support such as family and carer consultants, parent peer support and Children of Parents with Mental Illness programs • ensure that staff, consumers, families and support people are aware of sources of family and carer support, including peer support.
Opportunities	
<ul style="list-style-type: none"> • Increase opportunities for the employment of family/carer peer workers and for the co-design of family peer support programs. • Support the use of advanced care directives. 	
Resource materials	
<ul style="list-style-type: none"> • COPMI 2013, eLearning courses: 'Keeping children in mind' and 'Family focus' www.copmi.net.au/professionals/professional-tools/elearning-courses.html • Victorian Mental Health Carers Network 2013, 'Families as partners in mental healthcare: training for mental health professionals' www.carersnetwork.org.au/Families-as-Partners.php • Topor et al. 2006, 'Others: the role of family, friends, and professionals in the recovery process', <i>American Journal of Psychiatric Rehabilitation</i>, vol. 9, pp. 17–37 	

Domain 3: Supporting personal recovery

Capability 3A: Promoting autonomy and self-determination

Recovery-oriented mental health practice and service delivery affirms a person's right to exercise self-determination, to exercise personal control, to make decisions and to learn and grow through experience. Personal safety is upheld and service models are implemented that reduce if not eliminate the need for coercion.

Core principles	<ul style="list-style-type: none"> • Staff interactions with people using mental health services promote increased personal control. • Mental health services have a responsibility to respect people as partners in decisions affecting their mental health care. • People's personal experiences, understandings, priorities and preferences shape decision making concerning service responses. • Mental health services ensure the safety and promote the wellbeing and personal growth of people and commit to reducing, if not eliminating, coercion and involuntary interventions.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> • affording primacy to the wishes and views of a person accessing the service • respect people's right to self-determination • support people's decision making and respect their choices
Knowledge	<ul style="list-style-type: none"> • understand autonomy as fundamental to recovery • understand both recovery possibilities and limitations when coercion, seclusion and restraint are used • understand the importance of minimising involuntary practices like seclusion, restraint and involuntary treatment, and know how to reduce these practices • understand the importance of positive learning and positive risk taking to recovery • know ways to help people determine what happens in a future crisis, for example, by using advance directives • know mental health consumer advocacy and carer groups, and support their involvement in service delivery and decision making
Skills and behaviours	<ul style="list-style-type: none"> • actively inform people of their rights in service settings, support them in exercising those rights and remove barriers to their exercise of rights • help people to enhance their skills for informed decision making, including skills for obtaining, evaluating and applying information • engage with people in ways that heighten a person's sense of self-agency and personal control • help people to identify personal aspirations, goals and intrinsic motivators, including what's important for the person, what they want out of life, what they see as their most pressing challenges and difficulties, and what they want to do and change as a matter of priority • create nurturing environments where people feel sufficiently safe to challenge themselves, take positive risks and strive for growth
Recovery-oriented practice	<ul style="list-style-type: none"> • emphasise personal autonomy and self-determination in assessment processes and forms • use recovery and wellbeing planning tools that have been developed by and validated through lived experience • remove service barriers to people engaging in tasks of daily living • collaboratively explore strategies for avoiding coercion • promote the use of person-held service records

Capability 3A: Promoting autonomy and self-determination	
Recovery-oriented leadership	<ul style="list-style-type: none"> • incorporate and uphold principles of autonomy and self-determination in service policies and procedures • develop and implement evidence-based service models, models of care and practice skills that reduce coercion and the use of seclusion and restraint • ensure that any limitations on a person's choice, autonomy and self-determination are least restrictive as possible and removed as soon as practicable • maximise opportunities for autonomy and self-determination in referral, assessment, service coordination and discharge policies and procedures.
Opportunities	
<ul style="list-style-type: none"> • Establish opportunities for wellbeing resources to be designed and developed by people with a lived experience. • Establish on-site recovery programs—training and education delivered by people with experience of mental health issues www.nottinghamshirehealthcare.nhs.uk/our-services/local-services/adult-mental-health-services/recovery-education-college. • People can conduct their own research and prepare their own wellness and recovery plans, family plans, crisis prevention plans and advance directives using computer hubs and internet cafes. 	
Resource materials	
<ul style="list-style-type: none"> • RANZCP 2010, <i>Position statement 61: minimising the use of seclusion and restraint in people with mental illness</i>, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps61-pdf.aspx • Queensland Health 2008, <i>Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services</i>, www.health.qld.gov.au/mentalhealth/docs/sandrpolicy_081030.pdf • NMHCCF 2009, <i>Ending seclusion and restraint in Australian mental health services</i>, www.nmhccf.org.au/documents/Seclusion%20&%20Restraint.pdf • WRAP and Recovery Books 2013, 'The wellness tool box', www.mentalhealthrecovery.com/wrap/sample_toolbox.php • Andresen et al. 2011, <i>Psychological recovery: beyond mental illness</i> • Slade 2009a, <i>Personal recovery and mental illness: a guide for mental health professionals</i> • O'Hagan 2006, <i>Acute crisis: towards a recovery plan for acute mental health services</i>, www.maryohagan.com/resources/Text_Files/The%20Acute%20Crisis%20O'Hagan.pdf • Ashcroft & Anthony 2005, <i>A story of transformation: an agency fully embraces recovery</i>, www.recoveryinnovations.org/pdf/BHcare%20Apr%202005.pdf • Ashcraft 2006, <i>Peer services in a crisis setting: The Living Room</i>, www.recoveryinnovations.org/pdf/LivingRoom.pdf • Fulford 2007, <i>Values-based practice: a new partner to evidence-based practice and a first for psychiatry?</i> www.msmonographs.org/article.asp?issn=0973-1229;year=2008;volume=6;issue=1;spage=10;epage=21;au last=Fulford • Scottish Recovery Network, <i>Module 1: understanding recovery and Module 5: sharing responsibility for risk and risk-taking</i>, <i>Realising recovery</i>, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html • Recovery Devon 2010, <i>Recovery oriented prescribing and medicines management</i>, www.recoverydevon.co.uk/index.php/recovery-in-action/as-practitioners/80-recovery-orientated-prescribing-and-medicines-management 	

Domain 3: Supporting personal recovery

Capability 3B: Focusing on strengths and personal responsibility

Recovery-oriented mental health care focuses on people's strengths and supports resilience and capacity for personal responsibility, self-advocacy and positive change.

Core principles	<ul style="list-style-type: none"> • People have the capacity to recover, reclaim and transform their lives. • People with mental health issues want what everyone else does. • The personal resourcefulness, resilience and strengths of people with mental health issues are recognised and drawn upon. • A focus on strengths motivates and assists people to feel good about themselves and believe in their capacity for personal recovery. • Personal recovery begins when people reclaim responsibility for their wellbeing and decisions. • 'Nothing about me, without me'—a person is the director of the therapeutic relationship. • The preferred setting for service delivery is in the community. • Naturally occurring supports are preferred. • People draw on the resources and strengths of their families and close relationships, and on naturally occurring resources, to recover.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> • convey their belief in people's capacity to reach their aspirations and to shape a life rich in possibility and meaning • acknowledge and positively reinforce people's strengths and capacity for personal recovery • reflect a strengths focus in attitude, language and actions
Knowledge	<ul style="list-style-type: none"> • know strengths-based approaches to service planning, including the incorporation of elements of positive psychology • know and understand concepts of resilience
Skills and behaviours	<ul style="list-style-type: none"> • actively support people to recognise and draw on their strengths to build recovery skills and capacity for self-management of their mental health • support people as they build self-advocacy skills • work with people to understand what works well for them in their recovery efforts • foster people's belief in their capacity for growth as well as their capacity to fulfil responsibilities such as parenting and personal and household management • support people to self-manage distressing aspects of their condition like negative moods, voices, self-harm and suicidal urges • relate supportively with people when they are distressed • support people to self-monitor triggers and early warning signs • support people with medication management as well as physical health and wellbeing management • actively foster people's resilience and recognise its impact on recovery outcomes
Recovery-oriented practice	<ul style="list-style-type: none"> • incorporate methods of enquiry that encourage learning and using mistakes or setbacks as opportunities for growth • use collaborative assessment processes and service planning to amplify a person's strengths and assets, to foster responsibility, support positive identity and nurture hope • prompt people to consider what has worked well for them in the past • positively reinforce people's successes and achievements and encourage their translation into other life contexts • support family and support people to focus on strengths and to encourage personal responsibility

Capability 3B: Focusing on strengths and personal responsibility	
Recovery-oriented leadership	<ul style="list-style-type: none"> • foster opportunities within and beyond the service setting for people to apply and build on identified strengths • draw on lived expertise when incorporating strengths-based approaches into policies and procedures • use language in assessment processes, forms and tools and data collection that emphasises strengths and personal roles and relationships • encourage the co-design of new strength-based approaches and solutions with people who have a lived experience • model strengths-based approaches with staff and highlight the strengths of staff.
Opportunities	
<ul style="list-style-type: none"> • Use self-stigma reduction resources. • Adopt a strengths-based model of practice. • Develop information resources that promote positive messages and emphasise strengths. 	
Resource materials	
<ul style="list-style-type: none"> • Rapp & Goscha 2011, <i>Strengths model: a recovery-oriented approach to mental health services</i>, www.mindshare.org.au • Scottish Recovery Network, 'Multimedia', www.scottishrecovery.net/Multimedia/multimedia.html • Scottish Recovery Network, <i>Module 3: enabling self-direction</i>, Realising recovery, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html • Bird et al. 2012, 'Assessing the strengths of mental health consumers: a systematic review', <i>Psychological Assessment</i>, Advance online publication, doi: 10.1037/a0028983 • Leamy et al. 2011, 'Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis', <i>British Journal of Psychiatry</i>, vol. 199, pp. 445–452 	

Domain 3: Supporting personal recovery

Capability 3C: Collaborative relationships and reflective practice

Recovery-oriented mental health practitioners demonstrate reflective practice and build collaborative, mutually respectful, partnership-based relationships with people to support them to build their lives in the ways that they wish to.

Core principles	<ul style="list-style-type: none"> Recovery-oriented mental health practice and service delivery are built upon mutually respectful and collaborative partnerships. Supporting another person's recovery requires mental health practitioners to reflect on their own culture, values and beliefs and be aware of their own mental health. High-quality therapeutic relationships require ongoing critical reflection and continuous learning.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> demonstrate openness and willingness to learn from the person in recovery as well as from their family and support people value and warmly invite a collaborative relationship are open to adapting to people's different and changing needs and doing things differently convey respect for a person as an equal partner in the therapeutic relationship demonstrate a commitment to reflective practice and its role in authentic engagement and building mutually respectful and collaborative relationships
Knowledge	<ul style="list-style-type: none"> understand the impact their own culture, values and life experience have on their relationships and interactions with people using services know and can use a range of collaborative practices know and demonstrate proficiency in reflective practice
Skills and behaviours	<ul style="list-style-type: none"> acknowledge the possible impacts on people of the values, biases and beliefs built into professional training and service systems persist with engaging respectfully with those who have declined assistance or who do not feel motivated build trust and reciprocity with consumers encourage honest and open discussion of areas of agreement and disagreement as well as difference in values and priorities collaboratively work through differences of opinion, negotiate and resolve conflict and establish a mutually acceptable compromise or middle ground acknowledge and explore power differences in the therapeutic relationship and their possible impacts where appropriate, share aspects of one's own life experience to empathise with a person as well as to amplify a person's sense of motivation
Recovery-oriented practice	<ul style="list-style-type: none"> within a collaborative, partnership-based relationship, offer knowledge about the best available treatments and supports offer professional expertise to alleviate distressing symptoms, minimise the impact of mental health issues and prevent relapse, hospitalisation and harmful risk encourage honest discussion and collaborative decision making about treatment choices, including medication and its role alongside a wide range of other types of resilience-promoting supports, skills and strengths

Capability 3C: Collaborative relationships and reflective practice	
Recovery-oriented leadership	<ul style="list-style-type: none"> • provide opportunities for staff to recognise, reflect on and celebrate a person's recovery achievements and outcomes • build opportunities for consumers to be involved in service change, practice development and professional development • incorporate a focus on collaborative practice in policies and procedures as well as in recruitment, professional development and continuous quality improvement • recognise that good collaborative care takes time, both time spent with people and within the team • support staff to prioritise the space and time necessary for collaborative and reflective practice.
Opportunities	
<ul style="list-style-type: none"> • In collaboration with people with lived experience of mental health issues develop resources to support the building of collaborative therapeutic relationships. 	
Resource materials	
<ul style="list-style-type: none"> • Oades et al. 2005, 'Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness', <i>Australasian Psychiatry</i>, vol.13, no. 3, pp. 279–284 • Mental Health Association of Central Australia, 'Helen Glover: collaborative recovery training program', www.mhaca.org.au/helen-glover-training.html • Scottish Recovery Network, <i>Module 2: using self to develop recovery-oriented practice</i>, Realising recovery, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html 	

Domain 4: Organisational commitment and workforce development

Capability 4A: Recovery vision, commitment and culture	
A recovery orientation emanates from the vision, mission and culture of a mental health service.	
Core principles	<ul style="list-style-type: none"> The primary goal of a mental health service and of mental health practice is to support personal recovery. The belief in a person's capacity to recover is communicated in the organisation's vision and inspires and drives service delivery. The physical, social and cultural environment of a service inspires hope, optimism and humanistic practices.
Characteristics	Mental health providers...
Values and attitudes	<ul style="list-style-type: none"> view the promoting of personal recovery as core business rather than additional business demonstrate organisational commitment to learn from people with lived experience of mental health issues about how best to support personal recovery efforts demonstrate commitment to maximise opportunities for people to develop self-direction and self-responsibility
Knowledge	<ul style="list-style-type: none"> are abreast of emerging best practice related to supporting personal recovery and maximising a person's decision making and control know tools, resources and training for recovery-oriented cultural change understand that the expertise and knowledge required to promote recovery comes from both within and beyond mental health services support staff to reflect on their own lived experience of mental health issues and to use this knowledge appropriately
Skills and behaviours	<ul style="list-style-type: none"> embed recovery values and principles in the organisation's mission statement, philosophy, language, strategic plan, promotional material and website embed recovery principles, values and language in assessment tools and forms, service plans, consumer records and service delivery reports embed recovery principles in recruitment, supervision, appraisal, audit, planning and operational policies and procedures use recovery language in all correspondence include the fundamentals of recovery-oriented practice in staff induction, orientation training and ongoing professional development
Recovery-oriented practice	<ul style="list-style-type: none"> actively seek and use knowledge, information and feedback from people with lived experience of mental health issues and their families to innovate and improve services foster connections between lived experience and professional expertise to create a collaborative body of knowledge celebrate success in increasing the recovery orientation of practice and service delivery
Recovery-oriented leadership	<ul style="list-style-type: none"> champion the organisation's recovery vision, commitment and culture champion the participation of a diversity of consumers, families and carers model recovery language, values and principles in all aspects of their work include a commitment to proficiency in recovery-oriented practice and service delivery in position statements, service agreements and contracts ensure workplaces are safe, healthy, supportive, nurturing and recovery enhancing champion peer-run services and programs provide staff with ready access to information, research and resources that help to embed recovery-oriented principles and practice in the organisation review the time and resources required to implement and sustain recovery-oriented practice and service delivery.

Capability 4A: Recovery vision, commitment and culture
Opportunities
<ul style="list-style-type: none"> • Bring together people with lived experience, their families and carers and practitioners to discuss how to increase the recovery orientation of practice and services www.trialogue.co.
Resource materials
<ul style="list-style-type: none"> • RANZCP 2010, <i>Position statement 62: consumer and carer engagement</i>, www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps62-pdf.aspx • Sainsbury Centre for Mental Health 2010, <i>Implementing recovery: a methodology for organisational change</i>, www.centreformentalhealth.org.uk/pdfs/implementing_recovery_methodology.pdf • Sainsbury Centre for Mental Health 2009, <i>Implementing recovery: a new framework for organisational change</i>, www.centreformentalhealth.org.uk/pdfs/implementing_recovery_paper.pdf • NHS Education for Scotland/Scottish Recovery Network 2007, <i>Realising recovery: a national framework for learning and training in recovery focused practice</i>, www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/mental-health-and-learning-disabilities/publications-and-resources.aspx • Williams et al. 2012, 'Measures of the recovery orientation of mental health services: systematic review', <i>Social Psychiatry and Psychiatric Epidemiology</i>, Advanced Online publication, DOI 10.1007/s00127-012-0484-y

Domain 4: Organisational commitment and workforce development

Capability 4B: Acknowledging, valuing and learning from people's lived experience and from families, staff and communities

Recovery-oriented mental health services value, respect and draw upon the lived experience of mental health issues of consumers, their families and friends, staff and the local community.

Core principles	<ul style="list-style-type: none"> The lived experience of mental health consumers, their families and friends, staff and the local community is valued and respected. Recovery-oriented mental health services provide meaningful roles and positions, including leadership positions, for people with lived experience of mental health issues and mental illness (either personally or in their family or significant relationships). The organisational culture supports and empowers staff with lived experience of mental health issues to draw on that experience when responding to the people who use their services.
Characteristics	Mental health practitioners and providers....
Values and attitudes	<ul style="list-style-type: none"> are open to and enthusiastic to learn from, and be changed and challenged by, people with lived experience of recovery and mental distress and their families are committed to building a workforce with more professionals who have lived experience of mental health issues as well more peer practitioners/workers
Knowledge	<ul style="list-style-type: none"> understand participation issues for consumers in different settings and contexts—for example, forensic or compulsory settings—and know how to address these issues
Skills and behaviours	<ul style="list-style-type: none"> incorporate into their practice knowledge gained from working with people with lived experience of mental health issues support mental health professionals with lived experience to draw on their experience seek and obtain a representative view of what consumers think and use this information to drive and shape practice and service delivery provide opportunities for people in recovery wishing to learn from the peer workforce, for example, peer-led mentorship, coaching, education and training programs as well as traineeships and scholarships
Recovery-oriented practice	<ul style="list-style-type: none"> champion robust participation processes seek out advice from consumer and carer leaders and organisations support and collaborate with peer-run independent initiatives learn from colleagues who have accumulated experience and wisdom in incorporating their own lived experience of mental health issues into their practice
Recovery-oriented leadership	<ul style="list-style-type: none"> ensure that recruitment processes for all professional positions encourage applications from suitably qualified mental health professionals who also have lived experience of mental health issues/illness either personally, in their family or in significant relationships involve people with lived experience of mental health issues in decision-making processes (including recruitment processes) provide dedicated roles—including leadership positions—for people whose lived experience of mental health issues appropriately equips them to work within the service and who are resourced to develop roles and position statements provide the same management support, supervision and professional development opportunities to peer workers and other workers with lived experience as are provided to other professional groups bring together people with lived experience, family and carers and service providers in partnership and use their experiences to design, develop and improve services provide education and training programs conducted by peers and people in recovery for all staff, across all professions and at all levels provide opportunities for research and evaluation conducted by peers and people in recovery, and incorporate findings into quality improvement initiatives and ongoing organisational change.

Capability 4B: Acknowledging, valuing and learning from people's lived experience and from families, staff and communities
Opportunities

- Explore and develop new peer-run service models and programs, for example:
 - peer support in the community www.brookred.org.au
 - peer services in crisis and acute settings www.recoveryinnovations.org/pdf/LivingRoom.pdf
 - lived experience in clinical training and professional development
 - Hospital to Home canmentalhealth.org.au/resources/forms/hospital-to-home.html
 - peer support and hospital avoidance and discharge informahealthcare.com/doi/abs/10.1080/09638230701530242
 - warmlines (help and support telephone services) www.lifeline.org.nz/Warmline272.aspx
 - recovery colleges www.nottinghamshirehealthcare.nhs.uk/our-services/local-services/adult-mental-health-services/recovery-education-college/
 - peer support training.

Resource materials

- MH ECO: Experience Co-Design, www.mheco.org.au
- Scottish Recovery Network 2012, *Experts by experience: implementation guidelines*, www.scottishrecovery.net/View-document-details/328-Experts-by-Experience-Form-view.html
- Centre for Excellence in Peer Support Victoria, www.peersupportvic.org
- Daniels et al. 2010, *Pillars of peer support: transforming mental health systems of care through peer support services*, www.pillarsofpeersupport.org/final%20%20PillarsofPeerSupportService%20Report.pdf

Domain 4: Organisational commitment and workforce development

Capability 4C: Recovery-promoting service partnerships

A recovery-oriented mental health service establishes partnerships with other organisations both within and outside of the mental health sector.

Core principles	<ul style="list-style-type: none"> • Many services and supports outside the mental health system play an important role in helping to promote recovery and wellbeing by connecting people with their communities, traditions and cultures and reconnecting them with their developmental trajectories. • Partnerships can increase the efficiency of the mental health system by making the best use of different but complementary resources. • Mental health services and practitioners work through strong and sound service partnerships to support people to gain maximum benefit from locally available services and resources.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> • are outward looking and embrace service partnerships • welcome person-directed or initiated opportunities for new service partnerships and pathways • acknowledge that strong service partnerships enable holistic and comprehensive mental health care • recognise and value the expertise and contribution of other services • respect partnering agencies and their staff as equals
Knowledge	<ul style="list-style-type: none"> • maintain up-to-date knowledge of local services, resources, referral points and processes • maintain up-to-date knowledge of emerging evidence and best practice in service partnerships and service coordination
Skills and behaviours	<ul style="list-style-type: none"> • invest time, staff, materials, resources or facilities in service partnerships • coalesce with partners around the clear and shared goal of supporting personal recovery and a person's aspirations, choice and self-management • ensure that respective roles, responsibilities and expectations are clearly defined and understood by all partners • ensure that the administrative, communication and decision-making structure of the partnerships are as simple and easy to use as possible • standardise wherever possible common processes across agencies such as protocols, referral processes, service standards, data collection and reporting • use partnership analysis tools to reflect on and strengthen existing alliances and to establish new alliances • strategically, systematically and routinely draw on the strengths, knowledge, expertise and resources of other services to augment and support personal recovery
Recovery-oriented practice	<ul style="list-style-type: none"> • develop service partnerships to support people and their families to access the services and supports they require which may include health care, advocacy, education, training and employment, rehabilitation and support, exercise and nutrition, recreation, family support, childcare, housing and volunteering • access lived expertise in determining supportive, responsive, person-centred service partnerships
Recovery-oriented leadership	<ul style="list-style-type: none"> • validate and actively support service partnerships • build the requirement for service partnerships and service coordination into recruitment, professional development and continuous quality improvement • encourage and reward collaborative action by staff and reciprocity between agencies • take the time and resources to build effective partnerships and service coordination, with other services and within the team • support staff to prioritise the space and time necessary for good service partnerships and effective service coordination.

Capability 4C: Recovery-promoting service partnerships
Opportunities
<ul style="list-style-type: none">• Establish local recovery communities of practice.• Subscribe to and circulate the e-newsletters of community organisations.
Resource materials
<ul style="list-style-type: none">• VIC Health 2011, <i>The partnership analysis tool: a resource for establishing, developing and maintaining partnerships for health promotion</i>, www.vichealth.vic.gov.au/Publications/VicHealth-General-Publications/Partnerships-Analysis-Tool.aspx• Scottish Recovery Network, <i>Putting a network together</i> and <i>Sustaining a network</i>, www.scottishrecovery.net/Local-Recovery-Networks/supporting-resources.html

Domain 4: Organisational commitment and workforce development

Capability 4D: Workforce development and planning

Recovery-oriented mental health services prioritise building a workforce that is knowledgeable, compassionate, collaborative, skilled, diverse and committed to supporting personal recovery first and foremost.

Core principles	<ul style="list-style-type: none"> The vision for recovery-oriented organisations incorporates a workforce that is knowledgeable, compassionate, collaborative, skilled and diverse. Ongoing learning, skill development and reflection for recovery-based practice is built into an organisation's professional development processes and continuous quality improvement.
Characteristics	Mental health providers...
Values and attitudes	<ul style="list-style-type: none"> are open to changing, developing and embracing new work practices commit to being a learning organisation and to continuous quality improvement welcome lived expertise as a tool for strengthening organisational commitment to compassionate, person-centred ways of working are generous and share resources and knowledge through partnerships and collaboration to contribute to the development of a skilled workforce
Knowledge	<ul style="list-style-type: none"> know and understand the evidence base embracing new work practices required for an increased recovery orientation understand relevant legislation and its requirements regarding safety and rationale for coercive intervention seek knowledge in a wide range of fields to support recovery-oriented workforce development
Skills and behaviours	<ul style="list-style-type: none"> are proficient in using measures to assess the recovery orientation of the organisation collaborate with people with lived experience when formulating plans for organisational and workforce development build teams that are skilled and equipped to strengthen the recovery orientation of their practice and service delivery have a plan and infrastructure for supporting the personal and professional development of staff contribute to service innovation at all levels of the organisation
Recovery-oriented practice	<ul style="list-style-type: none"> have open and shared knowledge management recruit staff with the appropriate values, attitudes and knowledge to support recovery processes retain staff through a supportive, healthy and nurturing workplace recruit people with lived experience to applied lived experience positions and peer worker positions as well as people with lived experience who also have professional training and experience views applied lived experience as a discipline that contributes skills and expertise to mental health services builds a culturally competent and diverse workforce provide staff with opportunities to increase and enhance knowledge, engage in reflective practice and make progress in their careers provide equal opportunities for staff in supervision, mentoring and coaching so they can explore, critically reflect and learn directly from the wisdom and experience of others have effective performance management systems to assess workers' progress with supporting recovery and providing recovery-oriented services with indicators that are validated as well as relevant and meaningful to consumers and families

Capability 4D: Workforce development and planning	
Recovery-oriented leadership	<ul style="list-style-type: none"> reward strong, committed, inspiring and forward-thinking leadership enables, resources and supports staff to apply recovery-oriented principles and values to their practice work together and in partnership with consumers and their families to move the organisation forwards in recovery-oriented framework enable staff to perform at their highest potential in their roles of supporting personal recovery.
Opportunities	
<ul style="list-style-type: none"> Establish learning circles and communities of practice for applying recovery in life and work. 	
Resource materials	
<ul style="list-style-type: none"> Mental Health Coordinating Council 2008, <i>Mental health recovery philosophy into practice: a workforce development guide</i> www.mhcc.org.au/documents/Staff%20Development%20Guide/Introduction-revised.pdf 	

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

Capability 5A: Supporting social inclusion and advocacy on social determinants

Recovery-oriented practice and service delivery advocates to address poor and unequal living circumstances that adversely impact personal recovery.

Core principles	<ul style="list-style-type: none"> • People with mental health issues want to, and should be able to, enjoy the same social, economic and educational opportunities as everyone else. • Housing, transport, education, employment, income security, health care and participation are social determinants of health and wellbeing, and poor and unequal living conditions in these areas create disadvantage and poor health and mental health outcomes. • Because opportunity is a vital element of recovery, services ensure a focus on social inclusion. • Although mental health services are not part of a person's natural support networks, they can act as a conduit for people to their communities of choice. • Mental health services can play an important role in helping people to maintain naturally occurring supports and networks, access health care, maintain stable housing and take advantage of education, employment and other opportunities.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> • uphold the human rights of people with lived experience to participate in community and social settings that exist outside of mental health services • acknowledge the importance to personal recovery of naturally occurring supports, connections and opportunities • acknowledge that social exclusion or lack of opportunity can adversely impact on people's wellbeing • challenge barriers to social inclusion, including within their service
Knowledge	<ul style="list-style-type: none"> • understand that social inclusion is a determinant of health and wellbeing • understand the impacts on recovery of poor and unequal living conditions • know about community services and resources and actively support people to seek out information about the services they want • understand how self-stigma might impede a person from taking up naturally occurring opportunities for participation • maintain knowledge of current legislation, instruments, protocols and procedures governing people's human rights and legal rights: <ul style="list-style-type: none"> – <i>The United Nations universal declaration of human rights (1948)</i> – <i>The United Nations Convention on the rights of persons with disability (2006)</i> – <i>The United Nations Principles for the protection of persons with mental illness and for the improvement of mental health care (1991)</i> – antidiscrimination legislation

Capability 5A: Supporting social inclusion and advocacy on social determinants	
Skills and behaviours	<ul style="list-style-type: none"> draw attention to inequity and contribute to community partnerships to mitigate this support people to understand and act on their human rights and to self-advocate actively support people's access to naturally occurring community resources, supports and networks discuss recovery goals, make appropriate referrals and support access to services and resources that can contribute to: <ul style="list-style-type: none"> meaningful social engagement education, vocational training and employment opportunities income security housing stability general health and wellbeing outcomes help people and their families to get the most and best out of services—that is, to identify what they want from services, understand when and how to access services, build effective working relationships, make complaints, decide when to exit and so on are familiar with the criminal justice system and develop working relationships with police, justice, corrections and probation and parole
Recovery-oriented practice	<ul style="list-style-type: none"> use knowledge of human and legal rights and service systems to challenge social exclusion and disadvantage and to advocate for social justice are active partners in broad-based alliances that advocate for action on social exclusion and the social determinants of health and wellbeing
Recovery-oriented leadership	<ul style="list-style-type: none"> model a positive service culture that promotes inclusion of people using their services and their families at all levels regularly review support plans and service activities to ensure they are inclusive of naturally occurring social connections and opportunities for participation in the community collaborate to provide referral pathways into and out of services that can contribute to recovery outcomes validate and support the advocacy efforts of staff, consumers, families and communities input into relevant public inquiries and reform processes.
Opportunities	
<ul style="list-style-type: none"> Develop strong working relationships with community development officers in local councils. Use social media to promote community resource directories and information on community events, clubs, associations and services. Participate in Social Inclusion Week. Participate in and contribute to community festivals and events. 	
Resource materials	
<ul style="list-style-type: none"> Mental Health Coordinating Council 2007, <i>Social inclusion: its importance to mental health</i>, www.mhcc.org.au/resources/social-inclusion.aspx Victorian Department of Health, <i>Promoting social inclusion and connectedness</i>, www.health.vic.gov.au/healthpromotion/downloads/mhr_promoting.pdf UK Office of the Deputy Prime Minister 2004, <i>Action on mental health: a guide to promoting social inclusion</i>, webarchive.nationalarchives.gov.uk/+/www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/action_on_mh.pdf Slade 2012, 'Mental illness and well-being: the central importance of positive psychology and recovery approaches', <i>BMC Health Services Research</i>, vol. 10, no. 26, www.biomedcentral.com/1472-6963/10/26 	

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

Capability 5B: Actively challenging stigmatising attitudes and discrimination, and promoting positive understandings

Recovery-oriented practice and service delivery promotes positive understandings of mental illness and challenges stigma and discrimination.

Core principles	<ul style="list-style-type: none"> • Direct personal contact with people who experience mental health issues is the best approach to reducing stigma. • People with a lived experience of mental health can best design and deliver, antistigma education. • Empowerment helps people with experience of mental health issues to develop a sense of self-efficacy and thereby helps to combat discrimination and the internalising of stigma.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> • accept, value and celebrate difference • reject and challenge stigmatising and discriminating attitudes and behaviours • acknowledge that stigma and negative attitudes can exist within mental health service settings as well as being internalised among people with a lived experience
Knowledge	<ul style="list-style-type: none"> • understand concepts of stigma and discrimination and their impacts on people experiencing mental health issues, including internalised stigma • understand that stigma and discrimination can be experienced as trauma • understand stigma and discrimination in the health, mental health and related workforces • understand the role of media in both perpetrating and redressing discrimination • know antidiscrimination legislation, policy frameworks and mechanisms for complaint and redress • know best practice in stigma reduction—what works and how individuals, organisations and communities can assist
Skills and behaviours	<ul style="list-style-type: none"> • actively challenge stigmatising attitudes within service settings and engender hope and positivity among people with a lived experience • provide accurate information about mental health issues and promote positive messages and images • support people with mental health issues, their families and carers to work through self-stigma and their own negative beliefs and views • encourage and support appropriate disclosure
Recovery-oriented practice	<ul style="list-style-type: none"> • model non-discriminatory practice, including the use of non-stigmatising and non-discriminatory language • support and foster leadership of people with experience of mental health issues • facilitate and support peer-led antistigma campaigns and activities
Recovery-oriented leadership	<ul style="list-style-type: none"> • model a positive service culture that rejects stigmatising attitudes, policies and processes within service settings • audit service delivery against agreed antistigma criteria and act on any areas needing change • employ people with lived experience of mental health issues • acknowledge and promote the role of consumer and carer leaders within the service • ensure safe spaces for peers to meet, gather and organise • initiate peer-designed and peer-run programs and services • collaborate with peer-run services in the community • ensure organisational and staff participation in and contribution to local initiatives aimed to promote positive understanding and reduce stigma and discrimination.

Capability 5B: Actively challenging stigmatising attitudes and discrimination, and promoting positive understandings
Opportunities
<ul style="list-style-type: none"> • Make an organisational commitment to challenge stigma and discrimination. • Sponsor local awards and competitions that seek to address stigma by promoting positive messages. • Link to existing advocacy groups and activities from non-health areas (for example, sporting associations, the arts and media).
Resource materials
<ul style="list-style-type: none"> • See me, Scotland's national campaign to end the stigma and discrimination of mental ill-health, www.seemescotland.org • Like Minds, Like Mine, www.likeminds.org.nz/page/5-Home • World Health Organisation, 'Ottawa charter for health promotion', www.who.int/healthpromotion/conferences/previous/ottawa/en • VicHealth 2009, <i>The Melbourne charter for promoting mental health and preventing mental and behavioural disorders</i>, www.vichealth.vic.gov.au/Publications/Mental-health-promotion/Melbourne-Charter.aspx • Mindframe National Media Initiative, www.mindframe-media.info



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

Capability 5C: Partnerships with communities

Recovery-oriented practice and service delivery seek to maximise personal recovery by working in partnerships with local communities.

Core principles	<ul style="list-style-type: none"> • The experience of mental health issues provides a person with significant additional knowledge, resilience, skills and resources that can enrich local communities. • Communities value the resources and contribution of local mental health services. • A wealth of diverse knowledge, skills, strengths and resources reside in local communities. • As people with experience of mental health issues, local communities and mental health services have much to gain from each other, mental health services have a responsibility to assist to create opportunities for interaction and collaboration. • Communities—whether a few neighbourhoods or particular groups—are seeking to recover from events that have adversely impacted on their social and emotional wellbeing. • Mental health services have a role in supporting a community's recovery goals and efforts.
Characteristics	Mental health practitioners and providers...
Values and attitudes	<ul style="list-style-type: none"> • are known, respected and valued by their communities • welcome and initiate collaboration with local communities • have a vision for a mentally healthy community where people with experience of mental health issues flourish and have strong futures • value local diversity, knowledge, strengths and skills • understand and respect local expectations, traditions, customs and processes • supports to communities to be inclusive
Knowledge	<ul style="list-style-type: none"> • have an understanding of communities as social constructs and knowledge of evidence-based good practice in working with communities • understand and know their communities—community leaders, services and agencies, service clubs, schools, business chambers, local councils, sporting and recreation associations and so on • have up to date knowledge concerning sources of funding for community partnerships, capacity building, community development and volunteers
Skills and behaviours	<ul style="list-style-type: none"> • demonstrate skills of facilitation, networking and partnership building • use language that is readily understood • are proficient in harnessing or unlocking community goodwill, resourcefulness and creativity • support local promotion and prevention, early intervention, resilience, mental health literacy and capacity building initiatives • support peer-led community partnerships and initiatives
Recovery-oriented practice	<ul style="list-style-type: none"> • are active members of local interagency networks • partner with peer workers and local peer leaders when participating in community initiatives • collaborate with national and state-based community initiatives such as beyondblue, Rotary, MindMatters and Headspace • collaborate with national, state and locally based sporting, art, performing arts, recreational and volunteering organisations

Capability 5C: Partnerships with communities	
Recovery-oriented leadership	<ul style="list-style-type: none"> • acknowledge the importance of community partnerships to effective mental health care and to personal recovery • acknowledge community as the space for recovery, social inclusion and meaning for people • view recovery-enhancing community partnerships as core business and not a discretionary extra • acknowledge and reward staff for their role in community partnerships • acknowledge and make provision for the time and resources required • maintain organisational visibility and ensure organisational representation at important or locally valued events • when representing the organisation at community events and meetings, do so in partnership with local peer leaders • ensure sound working relationships with local media organisations.
Opportunities	
<ul style="list-style-type: none"> • Embrace National Mental Health Week and 'piggy back' on other national weeks and days, for example, National Heart Week. • Establish a field education program for postsecondary, undergraduate and postgraduate students undertaking studies relating to community development, capacity building, health promotion and prevention, community education, sport, exercise and physical education and event management. 	
Resource materials	
<ul style="list-style-type: none"> • Annapolis Valley Health 2013, 'Healthy and flourishing communities', www.avdha.nshealth.ca/program-service/mental-health-addiction-services/healthy-and-flourishing-communities • Scottish Recovery Network 2004, <i>Recovery and community connections</i>, SRM discussion paper series: paper 2, www.scottishrecovery.net/Local-Recovery-Networks/supporting-resources.html • Scottish Recovery Network, <i>Module 6: connecting with communities</i>, <i>Realising recovery</i>, www.scottishrecovery.net/Realising-Recovery/realising-recovery.html • McKnight & Black 2010 <i>The abundant community: awakening the power of families and neighbourhoods</i>, www.abundantcommunity.com 	

Glossary

Advance directive

See Psychiatric advance directive.

Capabilities

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

Carer

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

Clinical recovery

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

Coercion

Comprises seclusion and restraint—see definitions.

Diversity

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

Forgotten Australians

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

Involuntary treatment

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

Lived experience

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

Mental health practitioner

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

Mental health services (MHS)

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

Mental health service system

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

Mental illness

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

Peer support

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

Personal recovery

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

Practice domain

A field of practice.

Psychiatric advance directive

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

Recovery

See Personal recovery and Clinical recovery.

Recovery-oriented practice

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

Recovery-oriented service delivery

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

Restraint

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

Seclusion

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

Self-determination

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

Self-management

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

Sensory modulation

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

Stolen Generations

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

Trauma

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

Ulysses agreement

See Psychiatric advance directive.

Values-based practice

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

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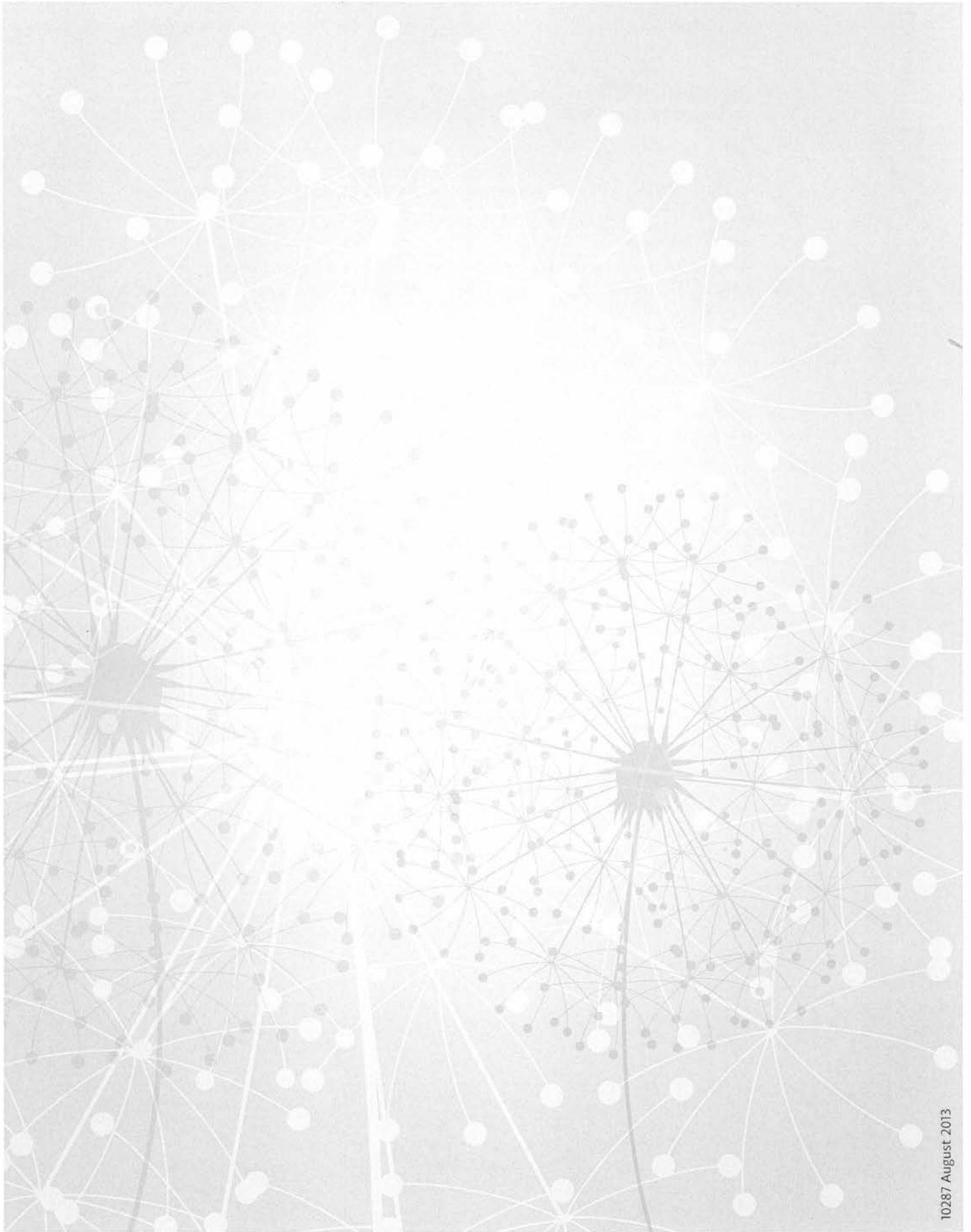
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