



What the consumer movement says about recovery

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The rise of recovery-oriented systems of treatment and support in the mental health field is widely acknowledged as a major achievement for the consumer-movement.

However, it was an achievement that was won with the help of a widely diverse range of supporters from many parts of the community with varying interests in mental health services. The partnerships which contributed to the development of the recovery paradigm in mental health services are still a vital resource in the field.

Long and determined efforts by consumer advocates to highlight the need for sweeping reforms of the mental health system, on the grounds of human rights, poor quality of services, and ineffective or even harmful treatment methods, were joined by many campaigners in the community over decades – including, many conscientious nurses, social workers, family/ carers, clergy, some journalists, writers, opposition politicians, community workers and action groups, human rights lawyers, unions, academics, a few reformist psychiatrists, and others.

This paper starts with an introduction about the role of the consumer movement in recovery-oriented mental health service delivery. Secondly, there is a Timeline of Recovery which traces a historical selection of key consumer related developments as the recovery model has taken shape between the 1960s and the present day. Thirdly the paper continues with a discussion of issues, implications, and emerging trends. The paper concludes with listings of recommended further readings.

Recovery-oriented mental health services are increasingly becoming the new standard, have a good deal of further potential for development, and are exerting a strong influence over the development of community-integrated services, because:

- Consumer participation can greatly facilitate new and innovative recovery-oriented treatment and support methods to resource and support the client/ consumer's chosen recovery outcomes.
- Partnership arrangements between consumers and service providers, with mutual respect and good communication are found to get much better results than adversarial tactics and criticism.
- The old "us and them" divide between staff and client/ consumers has long undermined progress in the mental health field, but building new partnerships with shared visions, and developing recovery-oriented, consumer empowering methods, should help banish many ghosts of an institutional past.
- Many consumers say that former services treated them at "arm's length" instead of relating to them personally, and people were told they would never recover or do the things "normal" people do. This has been likened to a self-fulfilling prophecy.
- Recovery oriented services need to have relevance and meaning to client/ consumers and reflect their lived experiences, hopes and dreams.
- There is a need to create community-based alternatives to institutional treatment; to reform and modernise the mental health service systems; to develop more effective medications and therapies; to foster the human rights and service user rights of consumers; and facilitate ways for consumers to return to participating lives in the community, in ways they find positive and meaningful.
- Some of the impetus for improving mental health outcomes should quite properly be focused within the community domain, rather than a tendency of characterising mental ill health as a problem discreetly located within each affected individual. Consumers often point out the stresses and traumas often found in modern society. It is only to be expected that there are differing degrees to which people can withstand the increasing stresses and competition in today's society.
- Support is needed for people who have fallen into homelessness or face other forms of disadvantage such as substance issues, deteriorating health, poverty, and marginalisation. Stigma and discrimination are well known adversaries in the mental health field, the value of community education is showing results, but more needs to be done.

The historical sequence leading up to the arrival of the "recovery paradigm" has been a far from linear process; has involved many diverse groups with many perspectives. It is inherently hard to make one's voice heard and persuade others on your views about multi-factorial and complex issues, and the progress towards change has been frequently delayed by miscommunications.

It was a crucial factor that such reforms have been championed by the mental health consumer movement and that consumers are helping to guide and implement reforms. Effective consumer participation, at various levels, has been proven to make a huge difference to assisting in the development of recovery-based services. Service providers and Carer Consultants and families, have also been vocal in calling for treatment and support that would make a bigger difference to the person.

The system which had to learn new and better ways

There is a fair degree of agreement with the view that the push for recovery-oriented systems of treatment and care was strongly linked to a growing consumer movement since the 1980s; was strengthened by deinstitutionalisation; further fuelled by the emerging era of psychosocial rehabilitation, which was primarily intended to assist consumers to move back into the community; and the emergence of the recovery paradigm was championed as a way for people to reclaim many things, including self and meaning.

A study by Dr Barbara Tooth and some colleagues in Queensland asked 57 consumers who considered themselves to be "in recovery" from schizophrenia about what factors had helped and hindered them on their recovery journeys. While the 1995 research may have been partly mitigated by later developments, some of the findings probably hold true.

Mental health professionals were not rated as particularly helpful, (with 39 per cent of participants citing support from mental health professionals as a helpful factor toward recovery) and (some 61 per cent citing poor experiences with professionals,) sometimes impeding progress towards recovery.

Philosophical lessons to learn (among many in a very readable report, see Further Reading, below) included that the staff who most helped recovery were those who showed extraordinary humanity and caring, and were prepared to “go the extra mile” and show consumers something approaching genuine friendship. The message coming out this important qualitative research funded by a Federal Government grant, was that consumers are vindicated in saying: *Just treat us as people, with care and compassion and we will get better.*

Recovery: A great destination – but how do we get there?

All stakeholders in the mental health field really do, I believe, have a duty to consider the evidence about the effectiveness, relatively speaking, of present recovery methods and approaches. Secondly, if we determine that recovery oriented approaches can make a difference to consumers, to what extent are our services capable of implementing such approaches. In other words, a great destination, but how do we get there? This presents a range of challenges in front of us, but they can be seen as creative opportunities rather than just problems to be solved.

As a leading example, consumer peer support – typically involving the employment of Peer Support Workers with lived experience of mental health problems, recovery journeys and appropriate training providing direct support and education to consumers, individually or in groups -- is an emerging area in mental health, expected to be a game changer in the mental health field.

There is a wealth of literature out there on recovery oriented approaches in mental health, including the writings by American consumer leaders including Dr Patricia Deegan, Shery Mead director of Intentional Peer Support, and in Australia, Cath Roper, a pioneer Consumer Academic, and Merinda Epstein, coordinator of Ourconsumerplace.com.au, an online resource centre.

In depth academic guidance can also be found in the extensive writings of Dr Larry Davidson and in America (Professor of Psychology in the Department of Psychiatry at the Yale University School of Medicine, where he directs the Program for Recovery and Community Health); and Dr Mike Slade, (a leading Consultant Psychologist and Academic in the (UK); and Yoland Wadsworth, a leading Australian academic expert on Participatory Action Research.

There are also recently released, substantial mental health recovery oriented services framework guidelines from both the Victorian and Commonwealth governments, which are about to get the backing of legislation and big on the ground rollouts, one example being the Adult Community Services re-design process now being implemented across NorthWestern Mental Health.

Such change processes are also include a taking stock of the evidence base around clinical recovery (including symptom reductions) and enhancement of education and training of clinicians, using a combination of approaches. There is a lot to work already in place, without the need to reinvent too many wheels.

Timeline of Recovery...How the mental health consumer movement contributed to the development of recovery-oriented services...1960s to 2014

Some highlights of the consumer movement's progress over the past half century

The 1960s:

The mental health consumer movement coalesced at this time of burgeoning social change movements, which had their strongest expression in America from the 1960s onwards.

These included the: **The black civil rights movement** and broader civil rights protests, including student movements, had a unique role in civil rights movements which were to follow.

The anti-conscription/ anti-war/ peace movement during the Vietnam was influential on the efforts of mental health consumer activists. The “peaceniks” regrettable shunning of the soldiers coming back from Vietnam exacerbated the physical and psychological wounds of the war, with trauma often compounded by injustice.

The women’s (liberation) movement delineated a wide range of issues about how narrow roles and opportunities in women’s lives could impact on their mental and physical health and wellbeing. Over the next five decades and beyond, the women’s movement influenced new and radical school of social theory, including Community Development and Participatory Action Research, which activists could use to help empower oppressed groups, by analysing power relationships, making explicit the structural underpinnings of oppression, and using many techniques to “facilitate networking for change.”

The so-called anti-psychiatry movement gathered strength in the late 1950s and 60s, with Hollywood film noir scary B-movies; expose’ type books alleging abuses in psychiatry; and books which attracted a large following, such as *“The Myth of Mental Illness”* by Thomas S. Szasz (1960.)

“One Flew Over the Cuckoo’s Nest,” a 1975 film based on a 1962 novel written by Ken Kesey, set within a psychiatric hospital, has made a seemingly indelible, mark on the public consciousness, often in unhelpful ways.

1970s:

The disability rights movement (including the developing notion of psychiatric disability) grew and the causes and effects of mental illness/ disability were increasingly debated, and increasingly the psychosocial factors, such social stresses, or traumas were highlighted.

1978:

A seminal book for the consumer movement was published in the USA – Judi Chamberlin’s “On Our Own: Patient Controlled Alternatives to the Mental Health System.”

PDRS services proved an ideal proving-ground for what was then still a nascent consumer movement. . These organisations and their peak body, Vicserv have grown into large entities, they remain in some ways friends and allies of the consumer movement and the legitimacy of the consumer voice.

1982:

Victorian Mental Illness Awareness Council (VMIAC) was formed during the International Year of Disabled Persons, has ongoing involvement in many major projects and is Victoria’s peak mental health consumer body.

1986:

The 15 Principles of Psychosocial Rehabilitation – which were based on consultation with many groups, including consumers – were published by the World Health Organisation and the University of Boston. This became a reliable guide for PDRS work – and importantly set the foundations for the coming recovery paradigm.

Around this time leading US consumer based advocates for recovery-oriented services garnered a rising profile. These included psychologist/ consumers **Dr Patricia Deegan, PhD** and **Dr Cheryl Gagne, PhD**. They are both passionate writers and speakers, and are recognised as pioneers of recovery based approaches in mental health.

1989:

The Understanding and Involvement (U & I) project at Royal Park saw this country's first use of consumer consultants in a consumer-focused/ staff collaborative evaluation of a public psychiatric inpatient unit. Many methods were used – but the researchers' pencil and notebook scored highly, because of the power of people's stories being quoted verbatim. The U & I project continued until 1996, and shortly after this, consumer consultants were employed in Area Services state-wide.

Between 1993-1998,

Victoria's mental health went through an enormous deinstitutionalisation process, where predominantly institutionalised services were replaced with a devolved system of community treatment, care and support services, but sometimes with problems along the way.

The Burdekin Report, (Human Rights and Equal Opportunity Commission) found that the deinstitutionalisation of mental health services had failed clients/ consumers, because of the under-funding of essential community facilities for those coming out of institutions, including housing, support, and crisis intervention. In hearings and submissions, consumers and others also provided a long list of grievances from the institutional days, including accounts of being mistreated, subject to coercion and that service cultures were often negative and custodial.

1994:

Victoria's Framework for Service Delivery establishes the pattern for Victoria's 22 Area Mental Health Services with their modular components, the multi-disciplinary teams to run them, and procedures for treatment and care. Later, community linkages, for example consumer shared care with PDRSs, GPs and other agencies are able to be added.

Consumer Consultants were employed state-wide for the first time, within Area Mental Health Services, opening many possibilities in consumer participation and over time, strengthening development of the mental health service system along recovery lines.

1999:

Neami Ltd, a PDRS in Melbourne's North, in policy development sought to bring together the principles of rehabilitation and recovery, and its working document said in part:

"Recovery is a consumer-centred experience, based, importantly, on a developed sense of self as the basis of coping and mastery of critical areas of life. It incorporates the realisation of capacity to act in one's own interests, of goal setting and testing out strengths through personal action." (Quoted with thanks to Neami.)

2000:

Ms Cath Roper was appointed as the state's first Consumer Academic, at the Centre for Psychiatric Nursing Research and Practice, Melbourne University. The position would include teaching postgraduate psychiatric nursing students about how consumer perspectives can inform service delivery.

2001:

The New Zealand Mental Health Commission – an organisation including a large contingent of consumer workers and with no Australian equivalent – publishes the *Recovery Competencies of New Zealand Mental Health Workers*.

Our Consumer Place, an internet consumer resource centre and clearinghouse was developed by an expert team of consumer activists/ researchers, (**Ms Merinda Epstein, Ms Cath Roper and Mr Jon Kroschel.**), and later an online newsletter was edited by **Ms Felicity Grey**.

2008:

New models of care open up in early intervention and alternatives to inpatient treatment such as the sub-acute Prevention and Recovery Care (PARC) program. (Step up, step down services.)

A service model called Personal Helpers and Mentors' Service (PHaMS) and a growing number of special projects, particularly in PDRSs, involving the employment of some Peer Support Workers, are likely to be a major new growth area in the mental health field.

2009:

Voices Vic, an innovative consumer-run peer support, education and advocacy group is launched, to explore and promote new approaches of supporting people who experience "hearing of voices." A statewide network of support groups has been set up.

2010:

The Mental Health Act of 1986 was due to be amended, after an extensive consultation and period on the table.

"What causes mental illness?" - a new collaborative website initiated by **Mr Bill Moon** is launched.

2012:

A VMIAC research project investigated the experiences of female consumers during their inpatient stays in psychiatric facilities across Victoria. The main focus of this year-long project is to speak with and gather information from female consumers about personal experiences of harassment or assault during inpatient stays or witnessing such incidents. This has been a matter of concern for some years.

2013:

Victorian and Commonwealth Governments both release framework documents aimed at facilitating the development of evidence based recovery oriented mental health services. These documents followed extensive consultation and are most helpful about how to implement recovery oriented methods.

2014: The Victorian Mental Health, is currently being re-drafted with a large number of reforms already foreshadowed, and is expected to be finally passed this year. The changes are expected to mandate the provision of recovery oriented services, give consumers a larger say in their treatment and support decisions, reduce the resort to involuntary treatment, reduce the use of restrictive practices, foster stronger partnerships with Community Managed Mental Health Services and other relevant organisations, and encourage partnerships between services, consumers and carers for service improvement and delivery.

The consumer movement as a champion of recovery:

Much of the momentum for recovery-oriented mental health services came from the burgeoning mental health consumer movement in the US. There were a number of consumer movement leaders who gained international recognition for their passionate and determined advocacy of recovery approaches.

Two of these were US psychologists with first hand consumer experience using psychiatric services, Dr Patricia Deegan PhD, and Dr Cheryl Gagne, PhD, but many more people joined the movement over time. (Some are named in Further Reading below.)

Dr Patricia Deegan (Deegan, 1988a) who was one of the early champions of the notion of recovery in mental health, as a consumer and PhD psychologist in the US, wrote:

“For many of us with [psychiatric] disabilities, recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, re-group and start again... The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability the aspiration is to live, work, and love in a community in which one makes a significant contribution.”

In suggesting consumer informed recovery-based principles and practices for mental health treatment and rehabilitations services, Dr Deegan, made a key distinction:

“It is important to understand that persons with a disability do not "get rehabilitated" in the sense that cars get tuned up or televisions "get repaired." People with disabilities are not passive recipients of rehabilitation services. Rather, they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability. This distinction between rehabilitation and recovery is important. Rehabilitation refers to the services and technologies that are made available to people with disabilities so that they might learn to adapt to their world Recovery refers to the lived or real life experience of people as they accept and overcome the challenge of the disability.”

Community participation a major key to recovery

From a consumer perspective – as someone with lived experience of serious mental illness and recovery journeys --I have learnt from my own journey and those of others I have met through consumer consultancy work, that the opening up of opportunities to live and participate in the community, *more fully and confidently, with appropriate supports*, is probably the single greatest contributor to progress towards personal recovery from mental illness.

While this type of personal recovery, being referred by the consumer movement and its supporters can lead to a reduction of symptoms -- directly or indirectly --it is actually understood to convey a sense of empowerment, renewed hope, a rekindling of one's aspirations or dreams, gaining more control over our lives and choices, having greater access to needed knowledge and resources, to achieve more positive self-esteem, and to see oneself as a worthwhile human being.

Professor Larry Davidson is the Professor of Psychology in the Department of Psychiatry at the Yale University School of Medicine, where he serves as Director of the Program for Recovery and Community Health. He discusses elements of recovery as follows:

“In addition to hope, recovery from mental illness, broadly defined, involves a process of overcoming some of the consequences of the illness; gaining an enhanced sense of identity; empowerment, and meaning, and purpose in life; and developing valued social roles, citizenship, and community connections despite a person's symptoms profile or continued disability. In recent years there has been a growing emphasis on mental health care that supports rather than hinders people's opportunities to participate in such processes of healing.”

Recovery, Peer Support, and Consumer Participation in the Community

The type of enhanced recovery-oriented approaches in clinical mental health services new policy settings are calling for, may involve:

- Peer support options and other linkages across a range of service settings, could help build for consumers renewed hope, wellbeing and strengthened recovery journeys.
- Stable and affordable housing, social connections, education, employment and primary health opportunities being put in place as essential requirements for recovery to happen.
- More fully integrating community partnerships frameworks, with consumers, carers/ families; Davidson and colleagues are critical of office bound methods of case management. A genuine “shared journey” is to be encouraged.
- Working in new and more collaborative ways, between MH services, consumers, family/ carers and other community partners, expanding potential for consumers’ recovery journeys.
- Dignity of risk is important – such as a person stepping outside their comfort zone” to create more normalised opportunities for progress.

The 15 Principles of Psychosocial Rehabilitation mentioned in the Recovery Timeline focus on similar rehabilitation and recovery issues, but may be in some ways more directive than the consumer version of how recovery-oriented services should look.

The principles include: helping client/ consumers develop their potential; emphasis on the person’s strengths; sharing life and social skills; self-determination; normalisation; catering to a range of needs; staff to work in a more informal, friendly way; a focus on early intervention and prevention of illness; work centred focus; social not medical model; and a “here and now” emphasis.

Definitions and understandings of mental illness influence discussions

It seems a further discussion can be had on a proposition that sometimes in mental health services it may not be clear what it is we consumers are recovering from in the first place. Much depends on how mental illness and mental health are defined and in the consumer movement there a variety of counter-discourses to the medical model about the nature of what we are dealing with.

Some would say that mental illness is a man-made construct, dependant on a doctor’s diagnosis from lists of symptoms the DSM IV. Theories about chemical imbalances of the brain and medication-led approaches are not popular with quite a number of consumers and do not seem to give much encouragement or scope for great personal effort or initiative.

Some consumers would say their problems came from being overwhelmed by life problems. Others say it has been a spiritual emergency. Some would say that it all began with unreported and/ or untreated childhood physical or sexual trauma, or other post-traumatic stress events. It has been suggested too that biological factors such as diet, sedentary lifestyles, and physical illness can also contribute to mental illness, and vice versa.

A leading consumer advocate, Ms Ria Strong, co-facilitating a consumer rep training session with me once spoke of *bio-psycho-socio-spiritual models of mental illness*. Clearly, a key message from the consumer movement on recovery is about one size not fitting all. And a key catch-cry for the consumer movement is: “Nothing about me without me.”

Spirituality, personal meaning as an “elephant in the room”

Questions of religion and spirituality and the place these things often play in a consumer’s life can be quite difficult matters to reconcile within a mental health context -- sometimes like a proverbial “elephant in the room” that no-one wants to talk acknowledge, much less talk about.

Spirituality and religion can sometimes manifest as a personal source of strength over adversity, but spirituality based issues can also be part of personal suffering, and sometimes may hold relevance to symptoms of illness.

There is a large unmet need for consumers to find ways to “work out” some of these highly personal areas, perhaps using various therapeutic and carefully designed opportunities to communicate; sometimes to come to terms with afflicted spirituality (perhaps involving *what is often called delusions*, or mood problems) which anecdotally seem to flow from adverse early religious upbringing, exposure to heightened religious fundamentalism, experimenting with illicit drugs, or other life pressures and traumas.

In a yet unpublished monograph, I have posed the question: **Why are matters of spirituality and religion so important for many mental health consumers...? “They say it’s all in the mind...”**

My opening statement says:

“Many people receiving treatment and support for mental health problems have a strong and legitimate interest in matters of spirituality and religion, for a range of reasons. Some see themselves as “seekers” of spiritual knowledge and wisdom, pursuing alternate beliefs, ideas and ways of being in the world. Many such idealists hope that more holistic of values will develop within mainstream society over time, challenging modern materialism, hyper-individualism and competition. Some people say they are seeking inner peace, greater wellbeing, and a more direct experience of the Sacred. Broadly speaking, many mental health consumers – or more simply, people seeking emotional healing – are experiencing psychological difficulties linked to the spiritually sensitive areas of one’s being relating to self-identity, meaning, purpose, introspection, and sense of belonging in society”.(Pinches, 2009)

Spirituality is an essential area to cover within a recovery framework, and is presently very under-addressed in mental health services, along with a number of issues which require time intensive one to one therapy. Often consumers find themselves tacitly discouraged from talking about these areas or feel too vulnerable to “open up” about subjects they think would just be pathologised, particularly by staff.

A possible approach that some consumers have found helpful in their own recovery journeys has been to place religion into a wider context of studying “spirituality” and/ or comparative religion and try to discern what life affirming or harmful, conducive to understanding life or being undermined by fear. Such exploration, with a little help from service workers, would be ideal for those using recovery-oriented methods.

Of course, another elephant in the room that also gets overlooked is the whole troubled question of sexuality and intimate relationships, which mental health consumers, as human persons, naturally want and need, but for a range of reasons tend to find their hopes difficult to achieve.

This is a difficult area to address and may be best linked in to other longer term strategies for social and community inclusion, such as: learning about enhanced social skills; the primary importance of being a friend; building friendship and supportive networks; getting involved with “real time” community activities or programs; efforts to build self-confidence and personal presentation; understanding the varying dynamics of relationships; and many other things.

In truth, there are all too many elephants in the room when we consider the lived experience of people who experience mental ill health, which seem to call out for a re-conceptualisation and greater humanisation of ideas and attitudes towards mental health consumers both inside the system and in society – particularly in the sense of “normalising the context” of how people are viewed. In other words, to look for commonalities in human needs, experiences, and attempts to take appropriate action, in the face of significant pressures on people, rather than focusing on differences between people.

Recovery competencies, standards, and some practical strategies

In the New Zealand “Recovery Competencies...” report – which was a forerunner in developing recovery approaches in Australia – recovery was defined in part as “the ability to live well in the presence or absence of one’s mental illness (or whatever people choose to name their experience.) Each person with mental illness needs to define for themselves what

‘living well’ means to them. The definition is purposefully a broad one because the experience of recovery is different for everyone and a range of service models could potentially support recovery.”

The document also maintained that competencies was defined broadly to include “attitudes, skills, knowledge and behaviour” required of the mental health workforce, and that services workers should also interact and draw upon people and communities.

The report also said: *“The recovery-based competencies should not just be treated as an add-on to current curricula or training standards. They signal a fundamental change to all aspects of the education of mental health workers.”*

Importantly, in New Zealand and in Australia this has meant increasing involvement of consumers as trainers and educators in the mental health field, and more recently the consumer workforce includes not only consumer consultant roles, but direct service provision jobs, as peer support workers and the like.

The proposed Australian National Standards for Mental Health Services #10.1 Supporting Recovery (These Standards have now been codified as Recovery Oriented Mental Health Policy framework documents at Commonwealth and Victorian Government level. However this present consumer discussion paper has not yet been updated in detail to reflect these developments.)

The broad policy objectives are aimed to ensure that services reflect recovery oriented values and principles under headings that can be summarised as:

- respect and dignity;
- focus on personal strengths;
- self-determination and autonomy;
- primary consumer participation in treatment decisions;
- positive family and social connections;
- social inclusion and citizenship;
- consumer participation in service development;
- linking with community resources; and,
- strengthening opportunities for carer involvement in treatment and support.

Consumers’ wants and needs, “hopes and dreams”

Notions of increasing access to the community, citizenship and “breaking free” over time from the constrictions, and sometimes stigma and discrimination, of a mental health consumer identity, and being able to have a life more ordinary, are all worthy themes. It would be good to see how many different ways consumers can live out these approaches, in exploring and developing such options.

The most keenly expressed needs of client/ consumers are sometimes characterised as the “Four Pillars” of normal life: a good place to live, a good job, a car and a loving relationship. These are also among the most difficult needs for people to achieve, partly due to the psychosocial factors associated with mental illness, stigma and discrimination. Accordingly, some compromises and willingness to build step by step towards goals over time is often a workable strategy.

Hopefully, as the recovery paradigm becomes more embedded into mental health services and the institutional-type walls of services, with their many limitations, continue to dissolve away, allowing more treatment and support to happen in more “normalised” community settings, these cherished hopes and dreams of client/ consumers will become increasingly achievable.

It is important for service provider staff to relate not only to the client/ consumer's needs and wants, but also their "hopes and dreams." While this may sound somewhat sentimental -- or a bit of a luxury that service workers don't have time and resources to take on -- if we don't factor in the person's "hopes and dreams" which are important innermost and holistic parts of that person's world, a large proportion of the person is not being addressed.

In fact, many consumers and service provider workers confidently state that hope is the very basis and beginning point of recovery-paradigm treatment and support, and is indispensable. And many consumers go on to say that it is only when they are able to dream of (or visualize) a better future that they can muster up some extra hope.

It is in the deepening supportive therapeutic relationship, the growing mutual trust and respect, and the changes that are unfolding, that we can see the flowering of the much prized and premium quality "shared journey" of recovery.

It is also often more productive to allow the consumer as much autonomy as possible, because decisions they make themselves, carried out ways they determine themselves, are more likely to engage the person's inner resources, determination and sense of personal meaning.

If people are pushed into things, this can actually perpetuate longstanding experiences of being repeatedly set up to fail, or a lingering sense of frustration. Just because the Government and Centrelink are running a "welfare reform agenda" should not automatically mean that such imperatives should be placed ahead of the person's recovery progress, in a manner where they can have "ownership" of their recovery in ways meaningful to them -- which can take time, but is generally worth waiting for. This type of recovery journey would tend to include a lot of life enrichment, with creative, and fun elements, not just employment oriented imperatives.

Some suggestions that I would make, to enhance the implementation of the National Recovery Standards #10.1- 10 include:

- Breaking down outdated and "us and them" institutional mindsets must continue with priority;
- Need to think and act more holistically about client/ consumers and their actual life contexts and actively apply self-reflective practices;
- Community education and development projects can help alleviate stigma and misinformation about people with mental health difficulties, because changing the social environment has been found to assist with recovery-oriented approaches.
- Need to embrace physical health and social wellbeing as important aspects of consumers' lives, which in the mental health consumer population is an area in need of urgent attention; and,
- Be guided by each consumer's needs and wishes about recovery, because each person's journey is unique. It is a privilege to be able to share in that journey.

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Suggested Further Reading:

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National Mental Health Consumers' Self-Help Clearing House (A large US based website with a range of consumer oriented information resources, links and projects. <http://www.mhselfhelp.org/>

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