



What the consumer movement says about recovery

By Allan Pinches,
Consumer Consultant in Mental Health,
Bachelor of Arts in Community Development (VU)
© Copyright 2009

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, 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 institutions past.
- Many consumers say that former services treated them at "arms 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.
- New service types can help consign to the wastebasket of history the complained of mistreatment and neglect of patients, believed to have arisen from negative effects of institutionalisation for consumers and staff, in the era of custodial care.
- 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 lives in the community, participating in ways they find meaningful.

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 being 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 superceded 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."

US psychologists White, Boyle and Loveland (2005) have written about a "qualitative shift" occurring in the conceptual foundation and design of behavioural health services. In an article which places the history and development of recovery approaches in mental health services within fairly conservative, evidence-based terms which some professionals may find particularly accessible. They write:

"Grassroots advocacy movements and a growing body of longitudinal research are challenging mental health and addiction treatment service providers to re-focus their services toward the goal and processes of long-term recovery... Today, well-organized ex-patient/consumer/survivor groups and visionary professionals are moving beyond the call for 'recovery-oriented' systems of care to actually creating such systems."

White et al, also state:

"A common theme... central to the consumer/ex-patient/survivor movement, is that recovery from mental illness must be defined as a complex, dynamic and enduring process rather than a biological end-state described by an absence of symptoms. Recovery is, in its essence, a lived experience of moving through and beyond the limitations of one's disorder. Viewing recovery in terms of an ongoing and highly personalized experience, rather than a biomedical disease, is a new and radical concept in the mental health field and one that requires a paradigm shift in how we think, how we design service systems, and how we conduct clinical research."

Timeline of Recovery...How the mental health consumer movement contributed to the development of recovery-oriented services...1960s to 2009.

Here follows a Timeline of Recovery which traces a historical selection of key consumer movement related developments, as the recovery model has taken shape, in Australia and overseas, between the 1960s and the present day.

It offers a contextual guide to the various developments and some indications of the discussions of the time, drawn from many documentary sources. However, it is not definitive account and there were many projects and developments going on across the period. This is also not intended as being more than part of **the recovery-based history** of the consumer movement. The story of the movement is much larger.

1960s:

The mental health consumer movement came into being in a time of burgeoning social change movements, which had their earliest and strongest expression in America from the 1960s onwards. These included the:

The black civil rights movement and broader civil rights protests on a wide range of issues were part of a time of social revolution, and many rights movements and self-help groups were starting up. The mental health consumer movement got underway in this time.

The-anti conscription/ anti-war/ peace movement during the Vietnam was influential on the efforts of mental health consumer activists.

The accumulated effects of soldiers coming back from Vietnam physically and psychologically wounded from the effects of war, chemical weapons and pervasive drug use, a high incidence of (PTSD) Post Traumatic Stress Disorder, and the regrettable shunning of returned Vietnam veterans by young “peaceniks” created a large pool of mental suffering for this group.

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 health and wellbeing. Over the next four decades and beyond, the women’s movement influenced new and radical school of social theory 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.” Such feminist social theory has been very influential on the formation of participatory action research, non-oppressive forms of social work and community development. It has also greatly informed and empowered consumer movement.

The hippy “peace and love” counter-culture movement of the 60s and 70s spawned many attempts at “alternative” therapies in the name of personal fulfillment (and in some ways mental health) – ranging from use of cannabis to “beneficially” get “high”; shaman-like experiments with the drug LSD; various types of meditation ; encounter groups; back-to-nature rural retreats and improvised ashrams in the countryside presided over by self-styled gurus; and an interest in the occult, partly as an alternative to “establishment” religions. Such practices may seem strange or excessive today, but many people pursued them with good intentions, and as viewed as social experiments may have, even incidentally, yielded up some valuable sociological insights.

Some new treatment modalities aimed at improving institutional mental health settings were also developed in the 1960s and 70s, in the form of popular “therapeutic community” methods, which encouraged consumers to share in decision making and responsibility for the running of programs and mutual support. Some elements of therapeutic community programs were used in inpatient units between the mid 1970s and mid 1980s, but were deemed not cost effective and also fell out of vogue, with the growing dominance of the medical model. Some therapeutic community approaches helped guide the coming new PDRS services, particularly with residential rehabilitation programs, notably the then Richmond Fellowship of Victoria (now Mind Australia.)

1970s:

The disability 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.

The New Age “spiritual supermarket” which reached the scale of “megabucks” commercially as well as being an outgrowth of the counter-culture, held many attractions and many traps for some people, who for a variety of reasons, may be vulnerable to mental health problems. Use of drugs such as cannabis has been a constant factor since this period.

Other more orthodox-appearing forms of spirituality and religions also contain traps for people who have difficulties assimilating these matters in relation to themselves and the world. The mental health system has been something of a “collection point” for people with such issues, and this is an area where it is important to seek out underlying causes. For instance, unfavourable religious upbringing or exposure to fundamentalism, or even religious abuse could often be a contributing factor to mental illness.

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.

Late 70s new non-clinical, community managed Psychiatric Disability Rehabilitation and Support services (PDRSs) such as the then Richmond Fellowship of Victoria and the Schizophrenia Fellowship of Victoria) were coming into being support the transition of de-institutionalised consumers into the community, and provide supported housing.

PDRS services proved an ideal proving-ground for what was then still a nascent consumer movement. While PDRS organisations have in many cases grown into large, corporatised, NGOs, and consumers say they miss the intimacy and ability of influence how the wheels go around, of the early years, these organisations and their 22 year old peak body, Vicserv, have been, and remain in many ways, strong friends and allies to the consumer movement.

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.

1988:

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. See Discussion and reference to Vicserv book "Towards Recovery" in Further Reading.

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, who are both passionate writers and speakers, and several large consumer groups became increasingly active, and were soon to become early and savvy users of the emerging Internet; Several are listed under Further Reading below.

1989:

The Understanding and Involvement 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 – some more effective than others. Overall, it seems the researchers' pencil and notebook were triumphant, because of the inherent power of revealing observations quoted verbatim. The U & I project continued until 1996, and shortly after this, consumer consultants were employed in Area Services statewide.

The U & I project set high and influential standards for theory and practice in consumer projects – particularly the *consumer participation/ staff collaborative approach*. It also produced five volumes of findings, models and methodologies for consumer perspective work, and a consolidated compendium was later published (Yoland Wadsworth with Merinda Epstein) in 2001. These books have sold in record amounts for consumer publications.

1992:

The Federal Government's National Mental Health Strategy was launched as a major vehicle for redevelopment and reform of the mental health sector. Many initiatives and large amounts of funding have sprung from this policy instrument. A succession of National Mental Health Plans were attached.

1993:

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 backup 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. The consumer movement could in some ways use this information as a reference point *for how things should never be*, and to help guide future positive changes.

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.

The Vincent's consumer peer support program at Albert Park was established and does much innovative work, providing peer support and streetwise information, and free training for peer support worker volunteers. The project was closed down in 1996, after the two years of Federal demonstration project funding was not renewed.

1996:

Consumer Consultants 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.

By this time the vast majority of Victoria's psychiatric system has been deinstitutionalised.

1997:

Consumer consultants Merinda Epstein and Julie Shaw conducted an influential *Lemon Tree Learning* project at the VMIAC, which explored ways of facilitating deep dialogue with service staff, to encourage more positive and helpful communication between staff and client/ consumers, aimed at encouraging better consumer outcomes. A new educational tool was a board game to be played by staff and consumers.

1999:

Neami Inc, 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." ... This would require many changes in service practices and cultures. The document continues: "We should be providing services that build a structure wherein consumers can safely explore options, experiment with choice making and risk taking and develop skills and confidence. We should be building bridges within mainstream community groups, playing an advocacy role, in addressing issues of access and participation."

2001: The New Zealand Mental Health Commission – including a large contingent of consumer workers and with no Australian equivalent – publishes the *Recovery Competencies of New Zealand Mental Health Workers*.

2002:

Clinical mental health services and PDRSs are increasingly setting up formal protocol arrangements, to facilitate shared – care arrangements and foster improved inter-agency cooperation. This tends to come

after a long process of workers getting to know and trust each other (breaking through some initial coldness) through social events, training, and working together with consumers; come to understand and respect the professional disciplines of each other; understand that it is OK to have different but complimentary roles in working with consumers.

Some PDRSs start to offer outreach respite support, aimed at giving carers and consumers a break. However, lack of respite services remains a major gap that carers and some consumers identify in the system.

2003:

Some consumer-collaborative/ peer support projects start to be established in Victoria, using models such as the social firm, which had been tried in the US, UK and parts of Europe, such as Ireland and Trieste Italy.

NorthWestern Mental Health undertakes an innovative rehab and recovery scoping project, which became the *Think Recovery* program.

2007:

The Victorian Government appoints Ms Lisa Neville as the state's first Minister for Mental Health, to help drive a reform agenda for mental health, including additional spending for mental health services and housing, under the Council of Australian Government (COAG) agreement; and widespread reforms under the strategic document "*Because Mental Health Matters.*"

Consumer advocates progress the consumer participation agenda to a new focus on the notion of "*primary consumer participation*" – giving people a greater say over their treatment and support decisions. Getting this part right often conditions the recovery based outcomes. Although it seems logical that this level being the closest contact between the consumer and a service provider, it can actually be a more difficult place for consumer participation to be successfully implemented (eg, compared to putting a few consumers on a committee or a doing survey.)

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.

A service model called Peer Helpers and Mentors' Service (PHaMS) and a growing number of special projects, particularly in PDRSs, involving the employment of Peer Support Workers, are likely to be a major new growth area in the mental health field. This should be an enriching process if overseas experience is a guide.

There would still remain a long "wish list" of many new and innovative types of more holistic and life affirming service options that might be possible in the mental health field. Many clients have spoken about how they view the system as too harsh and coercive, discouraging rather than supportive, perpetuating mental illness through negative service cultures and being too crisis driven.

2009:

The National Mental Health Standards are soon to include a new Standard # 10.1-10 on Recovery. A very useful document and the final consultation phase has just finished. (More in discussion below.)

The Mental Health Act of 1986 is to be amended in early 2010, following an extensive consultation period. Some consumer activists claim the consultation process was inadequate, and they said had not, as promised, strengthened human rights protections for consumers. Some other consumers emphasised their

belief that this exercise had been the best chance in 30 years to make comments that could re-shape the Act, and some welcome changes were on the way.

The Mental Health Act, according to the Community Consultation report of July 2009, is being re-framed and modernised in some ways to become more of a positive enabler – hence many new features likely to be compatible with recovery based approaches, which include:

- **More emphasis on “least restrictive environment”** treatment conditions and promoting meaningful participation and engagement with client/ consumers.
- Reducing the reliance on/ and reconfiguring involuntary admissions and treatment, CTOs and other orders and further regulating the use of other restrictive interventions.
- Improving methods of planning for recovery, (and better treatment plans generally) with a greater relevance to the person’s life circumstances, needs and wishes.
- Advance Statements (Directives) will be favourably considered for introduction as a way to empower consumers and promote more participation in their own treatment planning.
- More scope for involvement of carers and significant others.
- Monitoring and promoting care, wellbeing and rights to be enhanced by stronger oversight and complaint mechanisms.
- Greater attention to people with special needs, with a new highlight on children and young people.
- Better management of growing consumer complexity.

Controversy over the recent imposition of smoking bans in all Victorian psychiatric wards -- currently the subject of a petition of consumers and others calling for an exemption to be declared – raises questions about whether recovery from smoking addiction can be “forced” even for good health reasons, and whether it is bad timing to say the least, to stop client/ consumers smoking when they are in a locked hospital ward because of a major psychiatric episode. This decision has been claimed by some consumer advocates as “flying in the face of consumer empowerment principles” and “showing a complete lack of awareness of the lived experience of consumers.”

More positively however, it can be noted that the arrival of newly funded primary mental health programs in community, providing services to people with less severe but higher prevalence mental health conditions, such as anxiety and depression, eating disorders, social phobias and stress, might make a valuable addition to the consumer movement by: (1) helping to normalise mental illness in the community, (2) extending and creating greater diversity and strength in the consumer movement and (3) helping to break down stigma and discrimination in the community. Ultimately, these all have a bearing on the spread of recovery-oriented services.

Discussion:

The consumer movement as champions 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.) There have been many consumer movement luminaries in Australia too, who contributed many things to the recovery cause. Notably, their knowledge and creativity was able to attract quite a number of service provider collaborators in ushering in the recovery paradigm.

Dr Deegan (Deegan, 1988a) who was one of the early champions of the recovery cause, wrote:

“For many of us with 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.”

Dr Deegan went on to make some other consumer-based suggestions for recovery-oriented services, including:

- Recovery is not a linear process marked by successive accomplishments.
- Each person's journey of recovery is unique.
- Recognition should be given of the gift that people with disabilities have to give to each other.
- Hope is contagious and that is why it is so important to hire people with disabilities in rehabilitation programs.
- Finally, and perhaps most fundamentally, staff attitudes are very important in shaping rehabilitation environments.

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.

It may help to insert another helpful brief consumer-perspective overview of desirable recovery-oriented service approaches came from a paper by Leslie J Mitchell, a consumer advisor from Palmerton North, New Zealand, who wrote:

“Recovery is a process not an event. Recovery takes time (sometimes a long time); although there is no absolute time frame. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society. In the acute setting this social etiquette is basically working out what is meant by the term ‘partnership’; the relationship with the consumer and clinician/s.

“It is about recovering what was lost; rights, roles, responsibilities, decision making, potential and support. It is not about symptom elimination, but about what an individual consumer needs, how they can obtain it, and how others can assist/support the consumer to reach their goals. Recovery involves people having a personal vision of the life they want, seeing and changing patterns/behaviours, accepting symptoms so that a management regime can be implemented, which is authored by the consumer for the consumer.”

Recovery as a part of human experience:

The writings and conference speeches of Dr Patricia Deegan have been found by many consumers and service providers to be very inspirational and challenging, seeking to encourage everyone in the field to deeper thought and reflection about the human dimensions of mental health problems, so central to recovery-oriented services.

To paraphrase here, Dr Deegan wrote in somewhat poetic terms about a “dark night” of depression that some people experience for many days or even years; feelings of being hopelessly trapped within psychiatric illness/ disability; where life seems drained of much of its meaning and enjoyment; the person feels cut off from the world, some say seemingly beyond the reach of God; and a sense of futility and hopelessness depletes any motivation to “do” things. These parts of her writings fully merit reading in their own context, and are difficult to summarise here.

However, Dr Deegan also wrote about her belief that a full understanding of these experiences were beyond scientific or psychological jargon; hope being the prime element of recovery, before the will can become active; people who love us “cannot climb our mountain for us...but they are willing to suffer with us”; change can begin with a moment of grace, a spark of hope – a hope of being loved; “not a sudden conversion, or a bolt of lightning,” but a thought “I am willing to try”; not an end product or cure; not an end to pain and struggle...

Dr Deegan also warned that treatment and rehabilitation services should not impose notions such as rugged-individualism, self-reliance, independence, strong work ethic or academic based social values on participants – in fact any values which the client/ consumer has not consciously identified in a self-determined process.

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 are recovering from in the first place. Much depends on how mental illness and mental health are defined, and in the consumer movement there are many 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 visa 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 and the “elephant in the room”

Difficult as it is to reconcile within a mental health context, and sometimes like the proverbial “elephant in the room” that no-one wants to talk about, is the question of religion and spirituality and the place these things often play in a consumer’s life – sometimes as a personal source of strength, or a part of personal suffering, and sometimes relevant 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 delusions or mood problems) which anecdotally seem to flow from adverse early religious upbringing, exposure to heightened religious fundamentalism, or similar traumas.

This 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.

Recovery competencies, standards, and some practical strategies

In the New Zealand “Recovery Competencies...” report, recovery was defined in the blueprint 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 seeks 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

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 iterate 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, they are more likely to be motivated and more lively to have the accessible inner resources to help them achieve what they want. If people are pushed into things, this can actually perpetuate longstanding experiences of being repeatedly set up to fail. 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.

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;
- Using self-reflective practices to counteract any drift into stereotyped or negative thinking or talk about consumers, because this impedes progress and is the opposite of being treated with dignity, empathy and respect;
- 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.
- Moves to recognise the effects of stress, trauma, relationship issues, and financial distress and other social problems can help "normalise" the context of mental health.
- 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.

© Copyright Allan Pinches 2009

Email: Allan.Pinches@yahoo.com or Allan.Pinches@bigpond.com.au

Web: <http://ozfreedomwriters.blogspot.com/>

Postal Mail: PO Box 85 Kingsbury Vic 3083

Suggested Further Reading:

Dr Patricia Deegan. (1988 a). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11-19. An important article from this internationally noted consumer/ psychologist and leading writer on mental health recovery topics.

Dr Patricia Deegan (b from Conspiracy of Hope)
<http://www.namisc.org/newsletters/February02/PatDeegan.htm>

Human Rights and Equal Opportunity Commission (1993) (Burdekin) *Report of the National Inquiry into the Human Rights of People with Mental Illness*. Australian Government Publishing Service, Sydney.

Shery Mead (2008) *Intentional Peer Support: An Alternative Approach*. 302 Bean Road, Plainfield, NH 03781. sherry@mentalhealthpeers.com. (website on same domain.) Highly quality and thought provoking resource.

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

Leslie J Mitchell, Consumer Advisor, Mental Health Services
MidCentral Health Limited, Palmerston North, New Zealand:
e-mail: les.mitchell@midcentral.co.nz

Allan Pinches' blogspot: OZFREEDOMWRITERS: An Australian blogspot exploring community development based strategies for enhanced social, economic, health, and environmental outcomes. Mental Health Consumer Consultant and writer, Allan Pinches, now seeks to explore wider and more holistic horizons. [Site Includes key archived articles from his former website "Mental Health and Our Community."] <http://ozfreedomwriters.blogspot.com/>

LeRoy Spaniol, Martin Koehler, Dori Hutchinson: *The Recovery Workbook: Practical Coping and Empowerment Strategies for People With Psychiatric Disability*. Centre for Psychiatric Rehabilitation. <http://www.bu.edu/cpr/>

Barbara Tooth, et al (1999) Recovery from Schizophrenia: A Consumer Perspective. Final Report to the Human Services Research and Development Grants Program; and New Paradigm article February 1999.

Vicserv Inc (2002) Ed. Susan Pepper. *Towards Recovery. Psychosocial Rehabilitation: working with people with psychiatric disabilities*. New Paradigm Press. Melbourne. Includes page 41 a summary of the 15 Principles of Psycosocial Rehabilitation (World Health Organisation & Boston University 1988 and 1991.)

William A. Anthony, Mikal Cohen, Marianne Farkas, & Cheryl Gagne
Psychiatric Rehabilitation, 2nd edition; Forward by Courtenay Harding

William White, MA, Michael Boyle, MA, & David Loveland, PhD; (2005) *Recovery from Addiction and From Mental Illness: Shared and Contrasting Lessons*. (In Ruth Ralph and Pat Corrigan, Eds. *Recovery in Mental Illness: Broadening our understanding of wellness*. Washington DC: American Psychological Association.). Excerpt downloadable at: http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Annual_Minority_Mental_Healthcare_Symposia/recovery_from_addiction_and_mental_illness.doc.pdf