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FINAL RESEARCH REPORT

Enablers and Barriers to NDIS delivered Recovery-Oriented Psychosocial Disability Support

Stage Three

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Acknowledgement of Country

The research and project teams respectfully acknowledge the Wurundjeri people and the Boon Wurrung / Bunurong people of the Kulin Nation, who are the traditional custodians of the land where this report was created and pay our respect to their Elders past, present and emerging.

We recognise that Indigenous Australians have an ongoing connection to the land and value their unique contribution to La Trobe University, Mental Health Victoria, and the wider Australian society.

We recognise their lived experiences of colonisation and the strength and resilience of their living cultures and connection to Country. We embrace the spirit of reconciliation and commit to working towards community-driven and self-determining outcomes that ensure equality of outcomes and an equal voice.

CONTENTS

Background

This project has been commissioned by Mental Health Victoria (MHV) as a part of the *NDIS Recovery-Oriented Psychosocial Delivery Support Project: Growing National Workforce Capability*. The project aims to outline best practice in recovery-oriented psychosocial disability support (ROPDS), provide guidance for improving the NDIS psychosocial workforce capacity in recovery-oriented practice (ROP), and outline the capabilities for enabling ROP in the NDIS context. The project has been delivered in three stages. This final report is the third in the *Good Practice in Recovery-Oriented Psychosocial Disability Support* series.

Stage One: The Current Landscape

The first report, The Current Landscape, summarises a literature review that focused on the history of recovery paradigm; recovery-oriented practice; the current practice environment; enablers of good practice, and key considerations for Stage Two of the Project.

Stage Two: The Future Horizon

This synthesis report provides information to guide the MHV ROPDS Project team in developing a consistent national picture of the recovery-oriented capabilities required for psychosocial disability support workers. Additionally, the Future Horizon more directly explores how to address the workforce-related issues that impact effective ROP.

Stage Three: Final Report – Enablers and barriers to NDIS delivered Recovery-Oriented Psychosocial Disability Support (ROPDS)

In the third stage of the project, the research team has engaged in two main activities: 1) providing consultation to MHV during their conduct of the National Codesign Workshop Series and 2) the final report. This report describes the enablers and barriers to NDIS delivered Recovery-Oriented Psychosocial Disability Support (ROPDS) in Australia, building on the findings from the Current Landscape and Future Horizon reports. This Stage Three report:

- Identifies emerging issues, gaps in the literature and innovations in practice.
- Integrates the findings from the National Codesign Workshop Series by MHV with the Current Landscape and Future Horizon findings, focusing on the challenges and barriers to delivering ROPDS.
- Provides further recommendations for growing workforce capacity in ROPDS.

The reports in this series are targeted to address the NDIS workforce, governing bodies, organisations, peak bodies, and individual workers. However, the primary aim is to promote the interests of people with psychosocial disability and their families, carers and other supporters, who are participants of the NDIS. Key issues related to NDIS service delivery that have been considered are:

- Lived experience perspectives about recovery-oriented practice.
- Recovery and NDIS participants with psychosocial support needs including those who:
  - Have dual diagnoses, dual disabilities, or complex support needs;
  - Are from Aboriginal and Torres Strait Islander communities;
  - Are from Culturally and Linguistically Diverse (CALD) backgrounds; and
  - Are from LGBTIQ+ identity groups.

Further Information:

The Current Landscape: Good Practice in Recovery-Oriented Psychosocial Disability Support
The Future Horizon: Good Practice in Recovery-Oriented Psychosocial Disability Support

Key questions – What are we investigating?

- What feedback and changes have emerged from the codesign process for Stage One and Two of this project?
  - Is there new literature and programs to be considered?
  - Are there gaps in the literature?
- What findings have emerged from the National Codesign Workshop Series by MHV?
  - What are the barriers to recovery-oriented practice?
  - Are there unmet psychosocial support needs?
  - What do the findings add to the literature?

Method – What we did and how we did it

Additional academic and grey literature for the project update section was searched for using keywords linked to identified gaps emerging from the codesign process. These search terms were entered into Google Scholar and Google to further build on the comprehensive literature search undertaken and described in the Stage One and Two reports, the Current Landscape and the Future Horizon.

To further explore examples of innovative practice and resources not found through the systematic literature search, the following strategies were employed:

- Drawing on industry knowledge from the research team and MHV ROPDS Project team.
- Consultations with PRG members and other project stakeholders.

In addition, the MHV team thematically analysed and reported on the findings from the National Codesign Workshop Series Phase 1 and 2 reports utilising the frameworks and practice perspectives from the Current Landscape and Future Horizon reports. The findings from these National Codesign Workshop Series reports were also drawn upon in this Stage Three report.

Terminology

A note about the terminology used in this report: terms have been selected with care to convey respect for the people and groups who are referenced in this report. In the report, the terminology used is preferred by the NDIS or the Project Reference Group (PRG). Notably, many terms can have multiple definitions or meanings depending on their origins and contexts of use. Academic disciplines, stakeholder groups and governing bodies use different terminology over time. The terminology, particularly for specific concepts, has been selected with reference to the literature, which may differ from the preferred terms. The Current Landscape and Future Horizon provides a more detailed discussion of these terms and concepts.

See the Glossary of key terms for definitions and abbreviations for terminology used in this report (p. 49).

Coproduction and Codesign

Both the authors of this report and the MHV team recognise the valuable contribution of the lived experience perspectives that have influenced and informed this project. It is important to note that this report is not coproduced or codesigned however, it was guided by the principles that underlie these concepts. The research team included a lived experience researcher and other academics, all with extensive experience leading mental health research focusing on recovery and social justice.

The MHV ROPDS Project Team utilised a codesign methods for their project working closely with the Project Reference Group (PRG) and the Lived Experience Advisory Group (LEAG). As MHV describes:

> MHV recognises that coproduction is best practice, and that codesign is an element of coproduction. The Project's intent is to align as closely as possible to coproduction principles while acknowledging the constraints related to the project budget, resources, and timelines, particularly in the context of the remote working environment. To address these constraints, for the purposes of this project, a codesign process will be taken (Mental Health Victoria, 2021a, p. 5).

The PRG consists of consumer and carer lived experience members, representatives from industry stakeholders, national and state peak bodies and department representatives. As a part of the codesigned process embedded in the MHV ROPDS project, consultations with the PRG and leading stakeholders informed the outcomes and shaped these reports.

For the project, MHV also produced the National Codesign Workshop Series. These codesigned workshops and corresponding reports investigated ROPDS in the NDIS context (see section National Codesign Workshops and ROPDS). The workshops were conducted in two phases, the first with NDIS participants with a psychosocial disability and carers, and the second with NDIS psychosocial disability support providers and workers. The LEAG was instrumental in assisting in the production of content, presentations, and co-facilitation of the workshops.

For definitions of coproduction and codesign, see the glossary at the end of this report (p. 49).

Project Updates

This section focuses on additions and updates to the Current Landscape and Future Horizon reports. The project updates include additional material addressing gaps identified by the PRG and stakeholders and newly published literature not included in the original literature review.

As previously mentioned, an ongoing challenge was the paucity of literature available. Much of the literature is focused on clinical mental health services, not on psychosocial disability, and even less on the NDIS context. Consultations with the PRG helped the research team identify gaps in the literature, areas of need or concern for participants and their supporters, 'thin' sections of the project, and additional lived and industry expertise.

This section incorporates the following additional topics and resources:

- Structural competencies: health equity and financial wellbeing.
- Key priority groups: findings from the ReImagine Stage 2 project (Mental Health Coordinating Council, 2021b).
- Recovery-oriented supervision practices.
- Global Mental Health - World Health Organisation (WHO) QualityRights Initiative (2019a).
- Recovery-Oriented Practice Training Updates.

Finally, the NDIS Quality and Safeguards Commission (2021) Psychosocial Workforce Capabilities is compared with ROP principles and capabilities from the Future Horizon.

Structural Competencies: Health Equity and Financial Wellbeing

Emerging from the understandings of the social determinants of mental health and structural competency, some of the key challenges faced by people with mental health conditions, particularly those with a psychosocial disability, is physical health and financial security. In this section, we explore some of the impacts on people with a psychosocial disability and suggest some of the measures that can be employed in the NDIS environment.

In the Future Horizon report, the workforce capabilities for the social determinants and structural competencies are based around the principles of creating empowering conversations. These conversations assist the participant to understand the broader structural impacts on their lives and to have increased awareness of these issues when setting goals. Not all challenges can or will be addressed. However, these conversations aim to support and empower participants to make choices and direct their own goals relevant to addressing the social determinants of mental health. Notably, social determinants are intersectional, and inequities can be compounded and/or experienced disproportionately by different groups in the community. Structural competencies are demonstrated through:

- Knowledge and awareness of the structural inequalities that people with psychosocial disability commonly experience, in particular poverty, and how these may impact on engagement with the NDIS.
- Providing information and education to NDIS participants about the social determinants of mental health.
    - Exploring the existing structural and intersectional barriers experienced by the participant and how they may impact their lives.
- Promoting independence and supports informed choice.
- Discussing personal motivations, values, and aspirations of the participant to assist in goal setting and planning.
    - Supporting goal setting in each of the following domains: housing, employment, education, spiritual/religious; and physical activity/leisure/recreation.
- Focusing on the current strengths, expertise, existing solutions, and resources of the participant.
- Providing information and referral for additional supports including therapeutic, direct and practical support, and educational services.
- Exploring options and discussing challenges to assist in goal setting and planning.
- Facilitating self-advocacy of participants and their families, and participating in advocacy activities to address social justice and promote human rights at an organisational, and/or systems level.

  (Gajaria et al., 2019; Hansen et al., 2018; Neff et al., 2020; Weinstein et al., 2017; World Health Organisation, 2019).

These competencies outline the framework for assisting participants in the following domains of health equity and financial wellbeing, which intersect with the other domains of recovery-oriented practice.

Health Equity

The physical health of people with mental health conditions, disabilities and psychosocial disabilities is significantly different from that of the general community (Lalley et al., 2021; VicHealth, 2014). The impact of this disparity is so pervasive that people with mental health conditions have lower life expectancy compared to that of the general community (Firth et al., 2019), with reports ranging from 12 to 20 years difference (Australian Institute of Health and Welfare, 2020; Lalley et al., 2021). As discussed

in the Current Landscape report, intersecting factors such as the impact of racism and poverty can further increase this disparity.

The Australian Institute of Health and Welfare (2020) reported that people with mental health conditions are significantly more likely to experience significant chronic health conditions; including arthritis, asthma, back problems, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, kidney disease and osteoporosis. This health disparity is reflected in international studies, as demonstrated in a systematic review of 100 articles by the Lancet Psychiatry commission that reports mental health conditions are associated with a risk of obesity, diabetes, and cardiovascular diseases at rates 1.4 to 2 times higher than the general population (Firth et al., 2019).

Overall, the causation of these risks is mixed and intersectional. For example, many people with psychosocial disabilities and/or mental health conditions take daily medications with effects that can increase their health risk. Along with the symptoms of their condition, the adverse effects of medication can impact the ability to engage in healthy lifestyles or physical activities (Shor & Shalev, 2014). Additionally, people with mental health conditions are more likely to engage in smoking, problematic substance use and drink alcohol at levels associated with poor health (Australian Institute of Health and Welfare, 2020).

The structural impacts and the social determinants of health are also significant factors (VicHealth, 2014). For instance, financial disadvantage can impact access to primary health care (GPs and hospital treatment), ancillary health practitioners (psychologists, specialists, allied health providers) (Karban, 2017) and facilities for physical activities (gyms, pools, fitness centres) (Shor & Shalev, 2014). Notably, the NDIS does not provide funding for treatment or gym memberships but may fund allied health services to assist in capacity building, or core supports in accessing the community. Another dimension of social determinants is reduced social participation (Karban, 2017). Social participation may include joining sporting groups, outdoor recreation, clubs, and activities that promote physical activity and health (Karban, 2017; Shor & Shalev, 2014).

The challenge of this situation is to empower and support people with a psychosocial disability to engage in health-promoting activities to promote their autonomy, self-determination, and independence rather than perpetuating blame, stigma or low expectations. As VicHealth (2014) described in “The Enabling Health Framework”, addressing the social determinants of health is the overarching focus to improve the health and wellbeing of people with a disability.

Empowering conversations and coaching techniques are key strategies for supporting participants to explore their physical health aspirations and engage in goal striving. Notably, the use of micro affirmations, interactional processes, and building the relationship with the participant (Topor et al., 2018) are essential to ensure effective, respectful, and supportive communication (see The Current Landscape: Interpersonal Relationships p. 15).

Workforce capabilities associated with physical health include (see The Future Horizon: Recovery-Oriented Psychosocial Disability Workforce Capabilities):

- Understanding the interplay between physical health, mental health, disability and coexisting conditions and the importance of collaboration to address needs simultaneously.
- Understanding the specific health needs of participants.
- Knowledge of preventative health activities.
- Respecting and supporting participants’ decision-making capabilities.
- Identifying the physical health needs and health goals of participants.
- Engaging in preventative activities with the participant, where appropriate.

In Australia, emerging from the National Mental Health Commission, the Equally Well project has been launched to address the life expectancy gap experienced by people with mental health conditions (Equally Well, 2020). Notably, the project at this phase is primarily aimed at clinical guidance for primary health care and mental health practitioners (Morgan et al., 2021). The recently established ALIVE

National Centre (2021) for mental health research translation has three areas of focus: prevention, lived experience informed and improving health outcomes for people with mental health conditions. These aim to support longer, healthier lives in priority populations through bringing together mental and physical health care, redesigning systems for increased service identification, access to appointments and reduced costs and changing service cultures to reduce stigma and increase access to tailored, person centred care (ALIVE National Centre, 2021).

Financial Wellbeing

The impacts of financial disadvantage and poverty are discussed extensively in the Current Landscape (see section: Social Determinants of Health). As previously discussed, financial wellbeing is a leading determinant in both physical and mental wellbeing which has intersectional impacts with race, gender, LGBTIQ+ identity, disability, and other social determinants. This section will explore further supporting financial wellbeing to address this social determinant.

As highlighted in the research, people with a psychosocial disability may experience significant barriers to financial security and employment (Brandow et al., 2020; Devine et al., 2021; Elbogen et al., 2011; Harper et al., 2015; Harper et al., 2018; Jiménez-Solomon et al., 2016). Much of the focus of government policy is on promoting access to employment (Devine et al., 2021) and developing skills in budgeting and managing finances (Brandow et al., 2020). Notably, people with a psychosocial disability are one of the most vulnerable groups to experiencing homelessness (Beer et al., 2020).

A more holistic focus for supporting the financial wellbeing of people with psychosocial disability can utilise an economic inclusion model, which incorporates the experience of the individual and their families and broader structures that can impact their lives. Figure 1 shows some of the facilitators and barriers to economic inclusion that participants with a psychosocial disability experience.

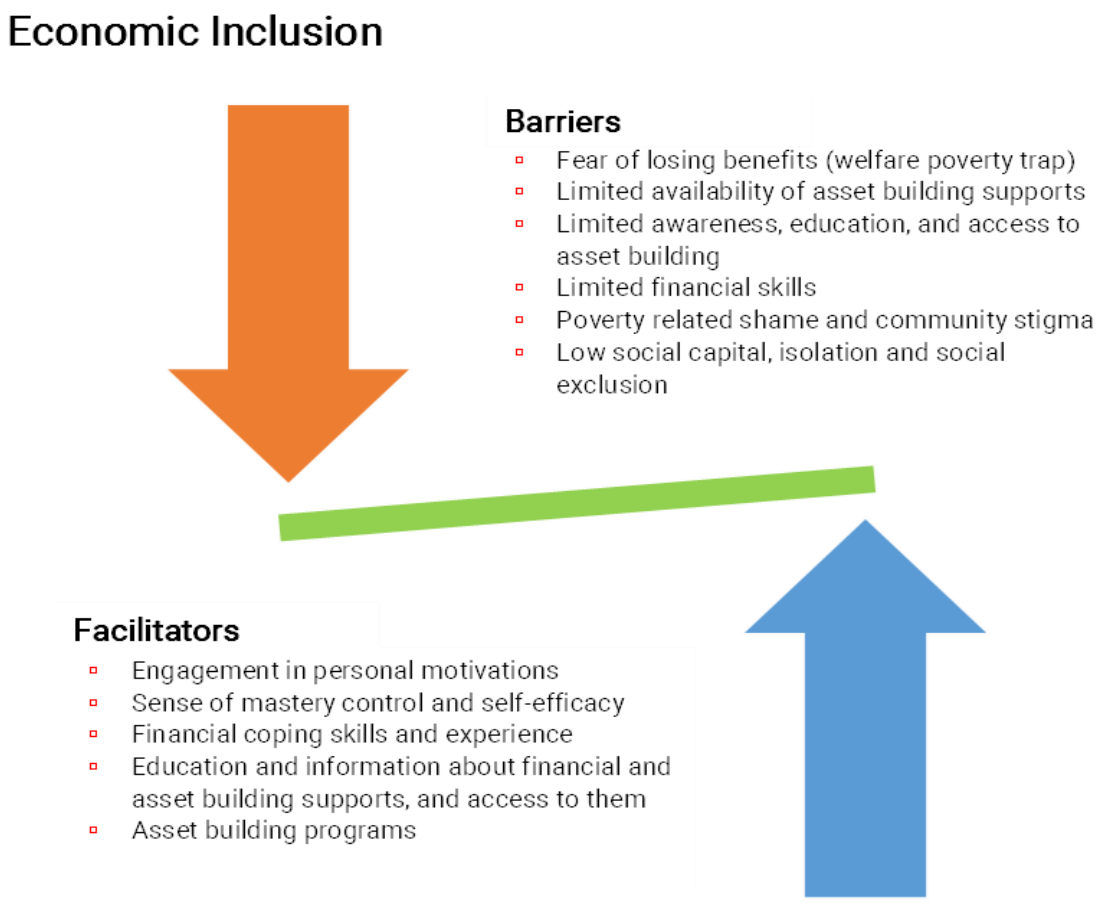

FIGURE 1: FACTORS THAT LIMIT OR FACILITATE ECONOMIC INCLUSION
Adapted from Jiménez-Solomon et al. (2016, p. 227).

Jiménez-Solomon et al. (2016) proposed a framework for supporting economic empowerment that has six elements:

1. Engaging individuals in culturally meaningful conversations about life dreams and financial goals,
2. Inspiring individuals to reframe self-defeating narratives by sharing personal stories,
3. Facilitating a financial wellness action plan,
4. Coaching to develop essential financial skills,
5. Supporting navigation and utilization of financial and asset-building services, and
6. Fostering mutual emotional and social support to achieve financial wellness goals.

(Jiménez-Solomon et al., 2016, p. 222).

Notably, the Jiménez-Solomon et al. (2016) framework promotes the use of providers with lived experience as a key to ensuring the empowerment and engagement of participants in promoting financial wellbeing, which they describe as financial wellness. The domains of financial wellness/being are described in Figure 2 below:

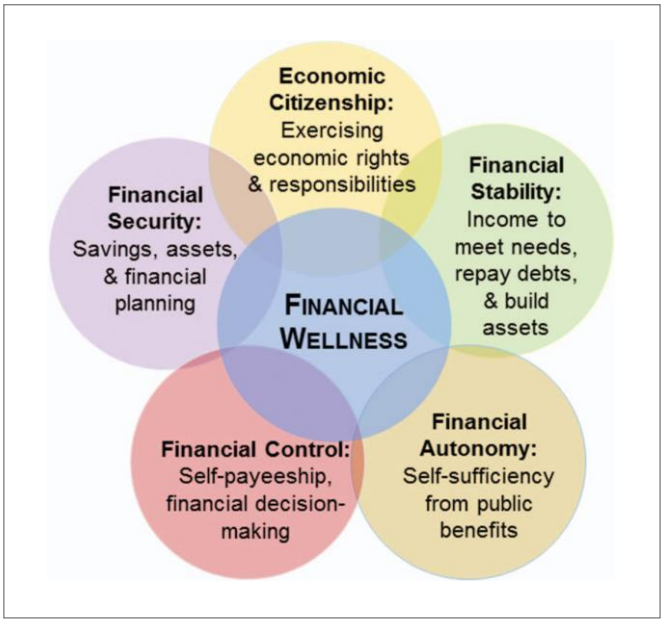

FIGURE 2: FINANCIAL WELLNESS.
From Jiménez-Solomon et al. (2016, p. 227).

Australian Policy and Financial Wellbeing

Income inequality is a significant challenge for people with a psychosocial disability. Several key Australian policies influence the financial wellbeing of NDIS participants with a psychosocial disability.

Traditionally, government policy to manage the financial security of people with a disability has been to provide or compel financial administration or management measures (Brandow et al., 2020). However, there has been a policy shift in recent years emerging from the *UN Convention on the Rights of Persons with a Disability* (UNCRPD) and other rights movements to ensure increased social inclusion and choice and control for people with a disability (Marston et al., 2016). For example, a guiding principle of the NDIS is that it is not means-tested and is considered exempt from income assessments (Department of Social Services, 2020). Similarly, the Disability Support Pension (DSP) is considered not taxable income; however, it is means-tested (Department of Social Services, 2022). Contradicting this shift, Marston et al. (2016) note a significant tension in Australian social policy with the introduction of compulsory income quarantine for certain welfare payments in some regions being inconsistent with the underpinning

values of the NDIS. This policy shift is of concern for NDIS participants with a psychosocial disability as 83 per cent receive the Disability Support Pension (DSP) (NDIS, 2020a).

To investigate the policy context, income and employment status data are explored along with the policy measures to support employment, financial management and housing. These areas are within the domains of the social determinants of mental health.

Employment

The *Employment Outcomes for NDIS Participants* report from the NDIS (2020a) provides a statistical analysis of various government data sources, and NDIS participant and household surveys. The employment rate of participants with a psychosocial disability at the commencement of the scheme was approximately 9 per cent (age 15 and over) (NDIS, 2020a). The commencing NDIS participants were likely to work part-time, with the majority working less than 15 hours per week (NDIS, 2020a).

In the longitudinal analysis of employment, discrete figures for psychosocial disability were not available (NDIS, 2020a). However, general trends of employment rates compared to the wider community showed that NDIS participants were employed at significantly lower rates (NDIS, 2020a). Additionally, the changes to employment status over four years were less favourable for NDIS participants, particularly those in lower age groups (NDIS, 2020a). In the report, the NDIS (2020a) surveyed NDIS participants to explore what conditions and supports were favourable to attaining employment. Notably, the NDIS reported that of the participants surveyed, people with a primary disability of psychosocial disability were significantly less likely to attain employment.

Considering the significant employment challenges for NDIS participants with a psychosocial disability, one of the central federal government policy efforts to promote financial wellbeing is the Australian Disability Employment Services Program (DES). As Devine et al. (2021) explore, the DES has recently undergone significant restructuring and privatisation. Echoing the NDIS, DES has espoused that a marketplace style service system will increase participants choice and control (Devine et al., 2021). In their research, Devine et al. (2021) found that many people with a disability face significant barriers to employment and exercising choice and control. Examples include:

- Trauma from service use.
- Compulsory engagement.
- Self-belief in decision-making.
- Limited knowledge about SPMI by providers.
- Low expectations of participants.

  (Devine et al., 2021).

As Devine et al. (2021, p. 25) describe, “for participants across all positions, their experience in DES continued a pattern of having their educational, career and life aspirations undermined and their capability for independence neglected”.

Financial Supports and Administration

The NDIS has two main mechanisms to assist participants in managing their finances and/or plan funding, financial capacity building supports and financial administration. Notably, financial administration is NDIS specific and designed to operate in conjunction with other supports and/or financial administration from other state and federal legislation and programs.

As many NDIS participants with a psychosocial disability experience financial hardship, financial capability building is an important element of ROPDS practice. Supports for financial capacity building are based on the NDIS participant’s goals, needs and aspirations. Where identified, capacity building supports for financial wellbeing may include training and education in financial literacy and money management skills and professional services such as financial planning and counselling (NDIS, 2021b). Most financial capacity building supports funded through the NDIS are aimed at building financial literacy skills, such as money handling, managing daily living expenses and budgeting. This is as the

NDIS only funds supports that are related to the participants' disability and not day-to-day living costs (NDIS, 2021b). Notably, these supports can empower participants to regain choice and control in several key areas. For example, NDIS providers have worked with participants to increase their financial literacy and management skills, which have enabled them to apply for financial administration orders to be rescinded (Ability Action Australia, n.d.).

NDIS providers may refer participants to other programs aimed at financial wellbeing. These programs may be NDIS funded services, government programs, private services, or non-government organisation (NGO) programs. NGOs are leading providers of financial wellbeing, education and counselling supports which are often funded through State and Federal governments. For example, the Financial Empowerment and Resilience Network (FERN) program offers online workshops aimed at financial wellbeing and economic empowerment (Brotherhood of St Laurence, n.d.-a). The FERN workshops include understanding superannuation, credit scores, taxation and creating financial goals (Brotherhood of St Laurence, n.d.-a).

Another key program aimed at promoting the financial wellbeing of people with a disability is MoneyMinded. MoneyMinded is a program that trains facilitators to provide financial education to groups or individuals in the community (Russell et al., 2017). Notably, people with a psychosocial disability and their carers were one of the leading groups participating in the program (Russell et al., 2017). For people with a disability, financial capability outcomes from the program included budgeting, financial decision-making, savings, and a positive outlook for the future (Russell et al., 2017). Carers reported financial capabilities in financial decision-making, increased confidence, and financial goal-setting. Carers also reported that the program offered a framework to assist themselves and the person they care for to navigate financial difficulty. Finally, participants reported that the educational style setting offered opportunities for connection to other people with a disability and carers, alongside the benefits of shared learning and experiences (Russell et al., 2017).

Financial planning services is another support for financial wellbeing. Notably, financial planning services may, in some instances, be funded through the NDIS. Financial planning can assist participants, families, and carers to navigate future planning decisions, disability insurance proceeds, superannuation access, special disability trusts and other financial matters.

The NDIS has multiple levels of financial administration, depending on the goals, needs and choice of the NDIS participant (NDIS, 2021a). Plan management is the primary form of financial administration in the NDIS. Plan funding can be partially or fully managed by a plan manager or managed by the NDIA in some circumstances.

The central role of plan managers is the financial administration of plan finances, such as managing payments to providers, monitoring funds, and financial reporting (NDIS, 2021a). Plan managers may also assist with financial capacity building supports to increase financial and NDIS plan management skills (NDIS, 2021a). Many NDIS plan managers also offer financial planning supports.

In some circumstances, an NDIS participant may be appoint a nominee who acts as a substitute decision-maker. A plan nominee oversees the NDIS plan, payments and correspondence. The legislation determining the NDIA appointment of a nominee is outlined in the *National Disability Insurance Scheme Act 2013* (Cth) and is considered a “last resort measure” (NDIS, 2020b). Notably, the appointment of a plan nominee in the NDIS system is not governed by a tribunal process such as found in state and territory systems, applications are submitted to the CEO of the NDIA.

Arising challenges have emerged since the inception of the NDIS due to the increased number of decisions involved in the NDIS process (Australian Law Reform Commission, 2014). Subsequently, there are concerns about the increase in applications for the appointment of state or territory decision-makers (e.g. guardianship and financial administration orders) by NDIS providers (Australian Law Reform Commission, 2014; Office of the Public Guardian, 2017).

Housing

Housing is another area that impacts the financial wellbeing of NDIS participants. The NDIS funds housing in the form of supported disability accommodation. However, due to strict eligibility

requirements, this is only available to a small number of participants (Beer et al., 2020). As Beer et al. (2020) state, many people with a disability experience significant housing challenges accessing affordable and suitable housing and are considered at high risk of homelessness (Beer et al., 2020).

Key Priority Groups: Findings from the ReImagine Stage 2 Project

Engaging and supporting diverse communities is also a key part of ROP, which emphasizes cultural safety and trauma informed practice. Improved engagement with diverse communities, including LGBTIQ+ identity groups, people from CALD backgrounds, and Aboriginal and Torres Strait Islander communities, are priorities identified by both the Royal Commission into Victoria's Mental Health System (2021) and the Productivity Commission's Inquiry into Mental Health (Productivity Commission, 2019).

The need to further support people from diverse communities and those living in rural and regional locations is also recognised by the Mental Health Coordinating Council (MHCC). In partnership with the NDIA, the MHCC has released its report *ReImagine Stage 2 Project – Findings from the Priority Population Co-Design Groups* (Mental Health Coordinating Council, 2021b). It builds on the work of the Reimagine Today project, which used co-design to build a resource that helps people navigate the NDIS. Reimagine2 extends this work to support people from diverse communities and those living in rural and regional locations. This resource is helpful in aligning current practice with ROP, although diverse communities should be further consulted when considering how to apply ROP in their community.

Aboriginal and Torres Strait Islander Communities

The findings of the ReImagine Stage 2 report outline two consultations with Aboriginal and Torres Strait Islander Communities from QLD and NT, in which participants reported that people have difficulty understanding and using the NDIS (Mental Health Coordinating Council, 2021b). It was also reported that web-based platforms could be difficult or impossible to access in communities where there is limited or no internet or mobile coverage (Mental Health Coordinating Council, 2021b). Use of picture communication and enlarged text was suggested to support those with low vision, this being a significant issue for many in the community due to the prevalence of diabetes. First Peoples Disability Network Australia (n.d.-a) has created the *Our Way Planning Book* to assist Aboriginal and Torres Strait Islander communities in telling their stories and preparing for the NDIS. Several videos were created to assist the community through learning from other people's stories (First Peoples Disability Network Australia, n.d.-b).

Key ROP related capabilities and competencies

The ReImagine Stage 2 report identifies the following points that could inform ROP capabilities for the NDIS workforce.

- Culturally and gender-appropriate support (e.g. being responsive to gendered cultural needs such as having separate pages for men's and women's pages in workbooks, providing options for choice of gender for workers).
- Community connection, not just individual emphasis.
- Understanding of Aboriginal history and culture, including impacts of colonisation.
- Inclusion of cultural connection, Indigenous representation (e.g. Aboriginal colours and symbols) and recognition of land and spirituality.
- Communication and language, including the use of picture communication support (e.g. timelines to show key milestones and when the plan runs out).
- Understanding of intersectional factors that impact Indigenous people.
- Knowledge of key services for Indigenous people, including an understanding of local Aboriginal community services.
- Ensuring access to NDIS supports particularly for Indigenous people experiencing homelessness or other complex needs.
- Working with the local Aboriginal community and Aboriginal Community Controlled Organisations and services.

It is important to note that the Social and Emotional Wellbeing model is the preferred model of care for working with Aboriginal and Torres Strait Islander Communities (Dudgeon et al., 2017). In the Current Landscape report, the definition and importance of the Social and Emotional Wellbeing model are explored (see History of Recovery). Reflecting the findings of ReImagine2, the importance of cultural safety, connection to culture and community, and a holistic focus are of particular importance for Aboriginal and Torres Strait Islander participants and their families. Notably, there is a paucity of literature that explores best practice in psychosocial disability support for Aboriginal and Torres Strait Islander communities and recovery-oriented practice. Therefore, the findings from ReImagine2 add to the emerging knowledge in this context.

Further information:

Aboriginal and Torres Strait Islander Peoples Hub – ReImagine Website MHCC
Our Way Planning – Video
First Peoples Disability Network Australia - Films

LGBTIQ+ Identity Groups

The findings of the Reimagine Stage 2 report detail two consultations with people who identify as LGBTIQ+ from NSW (face to face) and nationally (online) (Mental Health Coordinating Council, 2021b). Participants reported that people value NDIS organisations and providers having the Rainbow Tick (Mental Health Coordinating Council, 2021b). The Rainbow Tick signals inclusion and represents a base level of cultural competency and safety for the organisation (Jones et al., 2020). This is important for participants who have experienced stigma and discrimination or have had traumatic experiences from services in the past. Cultural safety for this group involves "professional empathy, reflective practice, an understanding of identity and culture; and addressing the impact of systemic discrimination on the health and wellbeing of LGBTI people" (Jones et al., 2020, p. 62).

Key ROP related capabilities and competencies

The Reimagine 2 report identifies the following points that could inform ROP capabilities for the NDIS workforce.

- Helpful communication methods (e.g. AUSLAN, picture-based communication, enlarged text).
- Intersectionality training.
- Communication rules, boundaries and expectations (e.g. rules of engagement' or 'what is/ is not ok').
- How to respond when a participant 'comes out' to you.
- Pronoun training and other language competencies (e.g. inclusive language guides (National LGBTI Health Alliance, 2013; State Government of Victoria, 2021), knowledge of LGBTIQ mental health needs and rights (Mental Health Coordinating Council, 2021a).
- Knowledge of community networks and LGBTIQ+ specific services.
- LGBTIQ+ specific mental health and suicide prevention competencies (e.g. safeTALK and suicide prevention (PHN North Western Melbourne, 2020).

Further information:

LGBTIQ+ Communities Hub – ReImagine Website (MHCC)
Rainbow Tick – Rainbow Health Australia Website

People from Culturally and Linguistically Diverse Backgrounds (CALD)

The Reimagine Stage 2 project conducted two codesign groups for people who have a multicultural background (Mental Health Coordinating Council, 2021b). These workshops included a mix of consumers and stakeholders, about half of whom were NDIS participants, carers, and support workers.

Key experiences included feeling looked down upon/dismissed, needing respite, and feeling embarrassed (Mental Health Coordinating Council, 2021b). The participants highlighted community attitudes around stigma, discrimination, and shame. They acknowledged that other people did not always understand and that education, engaging existing organisations and more promotion (e.g. face-to-face, DVDs, workbooks) might help (Mental Health Coordinating Council, 2021b).

It was noted that consumers and carers from CALD backgrounds might not be familiar with public services such as Medicare or the NDIS, and that they might be worried that they will need to pay for these services or fear being penalised (Mental Health Coordinating Council, 2021b). This may be why some participants cautioned that it cannot be assumed that everyone will ask for what they need.

The *Framework for Mental Health in Multicultural Australia* provides a framework and online training for practitioners and organisations to evaluate and develop their cultural responsiveness (Embrace Multicultural Mental Health, 2019).

Key ROP related capabilities and competencies

- Cultural safety training.
- Providing/supporting people to access information in their preferred language.
- Building communication.
- Community engagement.
- Stigma and discrimination reduction, including self-stigma.
- Understanding privilege and the impact of racism.
- Supporting choice and control through exploring participants values, preferences, wants and needs.
- Providing good, clear, and accessible information that has been determined to be helpful by community members.

Further information:

Multicultural Hub – ReImagine Website (MHCC)
Framework for Mental Health in Multicultural Australia – Embrace Multicultural Mental Health

Rural and Remote Communities

The ReImagine Stage 2 held two co-design groups with people from rural and remote communities from Tasmania and South Australia (Mental Health Coordinating Council, 2021b). Barriers that were identified by the participants included poor mental health services provision, staffing shortages (i.e. mental health, GPs, psychologists, psychiatrists) and challenges around continuity of care and a lack of clinical expertise (Mental Health Coordinating Council, 2021b). Also, the cost of travel to services and a reliance on regional hubs can be challenging for some. A sense of a 'cultural divide' between consumers and clinicians was described, which also reflects broader issues around stigma and discrimination (Mental Health Coordinating Council, 2021b). Complex issues related to privacy and confidentiality in small communities was noted. A greater need for peer work and innovations such as the community ambulance were highlighted. A lack of internet to access online support was also a challenge. The challenges to accessing the internet have important considerations for service delivery in rural and remote communities, where Telehealth and eMental Health has been promoted. Notably, eMental Health and the use of internet technologies is an emerging field with mixed evidence of its benefits and challenges (Bryant et al., 2018; Gammon et al., 2017; Lamonica et al., 2020; Williams et al., 2019).

Key ROP related capabilities and competencies

- Producing and distributing information and support.
- Providing information that is suitable for those who experience low literacy levels.
- Providing simplified information – broken down into easy steps.
- Education around what the term ‘psychosocial’ means.
- Strategies and methods for communicating in areas that do not have internet/phone/mobile connections.

Further information:

Rural and Remote Hub – Reimagine

Recovery-Oriented Supervision Practices

One of the enablers from the Current Landscape report was the need for the NDIS psychosocial disability workforce to have access to supervision. It is of note that the supervision models and types vary across different professions and contexts (Dawson et al., 2013). The focus of this update is to explore supervision that promotes a recovery orientation and is appropriate to the NDIS workforce and context.

Supervision

Mental health workers, including those working for the NDIS, should receive professional supervision for the benefit of both the worker and consumers with whom they work (Choy-Brown & Stanhope, 2018). Supportive practices such as supervision, reflective practice and mentoring can help ease tensions that mental health staff often grapple with, including the balance between functional or clinically determined processes and 'personal recovery' (McKenna et al., 2016). Supervision is a well-established practice that involves "relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleagues" (Milne, 2007, p. 439).

Traditionally supervision is provided to the worker at no cost by their employer as a part of good practice. People working in lived experience roles should receive lived experience specific supervision (Victorian Mental Illness Awareness Council & Centre for Psychiatric Nursing, 2018).

Evidence supports that supervision has many benefits. For example, a cross-sectional survey of 107 mental health providers found that supervisory relationship, alongside salary, caseload size, and the workers own level of personal anxiety, impact the development of secondary trauma in workers (Quinn et al., 2018) and therefore is of great importance to the NDIS workforce. In their systematic review of clinical supervision in mental health services, Bradley and Becker (2021) explored the characteristics and practices of two elements in supervision, formative (e.g. skills development) and restorative (e.g. wellbeing). For formative outcomes in supervision, the review found that supervisor expertise and knowledge of evidence-based practices was correlated with improved adherence and quality of service delivery (Bradley & Becker, 2021). Restorative supervision outcomes were associated with the supervisor–provider relationship and supervisory support (Bradley & Becker, 2021).

Despite the benefits, there have been reported challenges for supervision in both the mental health and NDIS contexts. An ethnographic study of organisational processes when introducing recovery-oriented care in an Australian private mental health care setting reported that the participants were able to attend fortnightly supervision, although many routinely "missed out" (Dawson et al., 2019). The barriers for supervision in the NDIS are reflected in two reports by Mental Health Victoria (formerly VICSERV) (2018; Sidlauskas, 2017), which identified unmet needs in the psychosocial disability workforce in training and workforce development. The report identified that in the NDIS context, barriers to supervision included availability, time and cost (Mental Health Victoria, 2018). In their analysis of a peer support program, Mackay et al. (2019) found that the NDIS funding model did not adequately account for the supervision needs of the peer workers.

Supervision frameworks for the Allied Health workforce have been released nationally and by the New South Wales, South Australian and Victorian state governments (Health Education and Training Institute, 2012; Health Workforce Australia, 2014; SA Health, 2014; State of Victoria, 2018b, 2019). Additionally, state government supervision guidelines have been released for mental health services (Queensland Health, 2009) and mental health nurses (State of Victoria, 2018a).

Recovery-Oriented Supervision

Recovery-oriented is a specific model of supervision which utilises the techniques of professional mental health supervision within a recovery framework underpinned by recovery values. As Yerushalmi and Lysaker (2014, p. 59) state, "one of the important ways to supervise professionals interested in internalizing the recovery approach in psychiatric rehabilitation is to implement its major principles in the supervision work itself". Yerushalmi and Lysaker (2014) suggest three principles for recovery-oriented supervision, 1) both consumers and supervisees are at the centre, 2) mutuality in the relationship with a focus on power and authority, and 3) the promotion of positive and empowering narratives and self-perceptions (for both the consumer and supervisee).

It has been recommended that recovery-oriented supervision enhances the benefits of recovery-oriented practice training (Sowers et al., 2016). A realist rapid review of 51 peer reviewed articles that address the long-term impact of recovery-oriented training found that modules addressing supervision were sometimes overlooked despite being an expressed workforce need that helps workers feel more (Gee et al., 2016).

The PULSAR secondary care project and study, aimed at training community mental health staff practitioners in recovery-promoting relationships, utilised monthly PULSAR Active learning sessions (PALS) as one of the three implementation strategies (Meadows et al., 2016). These PALS sessions utilised a model of coaching to embed the learning outcomes of the recovery-oriented practice training, practice their developing skills, explore coaching as an interpersonal style and provide follow-up (Meadows et al., 2016). Participants in the PULSAR training were encouraged to utilise their existing supervision arrangements to further explore their practice, reflecting on their recovery orientation and their relationships with consumers (Meadows et al., 2016).

Lived Experience Supervision

Lived experience supervisors have become increasingly utilised as the lived experience workforce has grown. Lived experience supervision is a discipline-specific supervision that is conducted in addition to line supervision. It supports lived experience practitioners to engage in lived experience specific reflection, explore new ideas and discuss challenges and dilemmas (Victorian Mental Illness Awareness Council & Centre for Psychiatric Nursing, 2018). This type of supervision is optimal for people practicing from a lived experience perspective in the NDIS, such as Lived Experience Recovery Coaches. The benefits of supervision for lived experience workers were explored in a single-case time-series study (Weikel et al., 2017). Weikel et al. (2017) found that participation in group-based peer supervision promoted improvements in the peer specialist's own recovery along with increases in their self-efficacy as a practitioner.

In their consumer-led participatory research, Bennetts et al. (2013) explored the issues experienced by consumer perspective workers in their roles in Victorian mental health services. The workers reported challenging working conditions and job demands, with wide-ranging attitudinal, resource and infrastructure barriers within services (Bennetts et al., 2013). Limited and underdeveloped educational and peer supervision options were also reported (Bennetts et al., 2013). Recommendations from workers included the development of leadership in the consumer workforce and mental health sector to improve working conditions and career opportunities (Bennetts et al., 2013).

In Victoria, the Centre for Mental Health Learning (CMHL) has developed a register of Lived Experience supervisors called the 'Consumer and Family Carer Perspective Supervision Database' (Centre for Mental Health Learning, n.d.). The CMHL in partnership with the Centre for Psychiatric Nursing, The University of Melbourne and The Victorian Mental Illness (VMIAC) has published the *Consumer perspective supervision: A framework for supporting the consumer workforce* (Victorian Mental Illness Awareness Council & Centre for Psychiatric Nursing, 2018). The framework emphasizes that Lived Experience workers are entitled to Lived Experience supervision. Further, it highlights key underpinning values and principles that are foundational to consumer perspective supervision, including self-determination, connection, mutuality, lived experience as expertise, responsibility, authenticity, transparency, hope, and curiosity (Victorian Mental Illness Awareness Council & Centre for Psychiatric Nursing, 2018). In 2021, the *Carer perspective supervision framework: A framework for supporting the mental health family/carer lived experience workforce* was released by CMHL (CLEW, 2021). The carer perspective framework provides workforce development resources for supervision with mental health carers in lived experience roles (CLEW, 2021).

Reflective Practice

Another key practice, in addition to supervision, is reflective practice. Recovery-oriented reflective practice groups are a staff-directed intervention aimed at achieving recovery-focused transformation in mental health services (Gabrielsson & Looi, 2019). The reflective practice groups use a framework aligned with recovery principles and consider the recovery process as relational (Gabrielsson & Looi, 2019). The framework of the groups is underpinned by a holistic and person-centred understanding of the consumer and utilise strengths-based and collaborative approaches with the staff member

(Gabrielsson & Looi, 2019). Gabrielsson and Looi (2019) suggest a structured approach to the reflection process, which include discussing these six questions: 1) What [incident/shared experience]; 2) What is it about; 3) Why do we care; 4) How can we understand this; 5) What can we do; and 6) Who does what?

Communities of Practice

Communities of Practice (CoP) are professional networks with a shared aim of professional development, knowledge sharing, innovation, and promoting change (Mental Health Coordinating Council, 2016; Piat et al., 2016). There are three characteristics of a CoP, which include a domain (area) of knowledge, a sense of community, and practice (focus of) knowledge (State of Victoria, 2021).

CoPs in the mental health (Barwick et al., 2009; Wimpenny et al., 2010) or recovery (Piat et al., 2016) context have some limited evidence of effectiveness in supporting knowledge translation and change implementation. However, they are well established in the education sector and have some evidence in the healthcare sector (Bate & Robert, 2002; Ranmuthugala et al., 2011).

In Australia, CoPs are well established in several locations for the mental health, psychosocial and lived experience workforces. In the Hunter Valley NDIS rollout, MHCC established a CoP to increase the capacity and supports of the psychosocial disability workforce (Mental Health Coordinating Council, 2016). Emerging from the Hunter Valley CoP project, MHCC (2016) released the *Guideline for Establishing a Local NDIS Community of Practice to Enhance Learning and Sector Reform*.

Research with Canadian CoPs has found that they support evidence-based practice implementation with mental health practitioners (Barwick et al., 2009). In the study, CoP participants had improved, knowledge, used the knowledge more readily in practice and reported higher satisfaction levels with implementation supports (Barwick et al., 2009). Piat et al. (2016) found that CoPs can assist in improving organisational performance, reduce professional isolation and facilitate the implementation of technologies. The creation of CoPs and networks for ROPDS could improve the efficacy of the implementation measures.

The reported findings that indicate reduced isolation (Piat et al., 2016) and perceived support during change implementation (Barwick et al., 2009) have implications for the role of CoPs in ROPDS. Given that most NDIS roles are based in community settings or in participants' homes, many NDIS workers have limited contact with their colleagues and managers. CoPs may assist NDIS support workers to have increased connection with their colleagues and access to supports. Isolation has emerged as a key issue for the NDIS workforce in a recent study in Victoria. The *Understanding the workforce experience of the NDIS: longitudinal research project – Year three* found that isolation had significantly increased in the 2018 – 2020 period, from 63 to 72 per cent (State of Victoria, 2021). As NDIS workers reflected, "the ability to debrief with colleagues and team management who understand the nuances of issues faced was most beneficial for stress management and overall wellbeing" (State of Victoria, 2021).

In Canada, CoPs have been utilised to assist in a social action approach designed to improve recovery outcomes for consumers. In Quebec, Canada, a recovery CoP was created aimed at improving recovery outcomes for consumers (Piat et al., 2016). Notably, this CoP had a participatory focus and consisted of researchers, practitioners, managers, and service users (Piat et al., 2016). The paper reported that the CoP was able to meet some of their initial objectives, with particular success advocating for recovery to be designated a priority in the *2015 – 2020 Quebec Mental Health Action Plan* (Piat et al., 2016, p. 11).

Global Mental Health - World Health Organisation (WHO) QualityRights Initiative

As the WHO (2019a) describe, the QualityRights Initiative has been developed to increase the capacity of mental health providers and practitioners to implement a human rights and recovery approach. As they state:

> The ultimate goal of WHO's QualityRights is to change mindsets and practices in a sustainable way and empower all stakeholders to promote rights and recovery in order to improve the lives of people with psychosocial, intellectual or cognitive disabilities everywhere (World Health Organisation, 2019, Para. 2).

The WHO Guidance on Community Mental Health Services (2021) emerged from the WHO QualityRights Initiative. The guidance and accompanying technical packages provide further information "to support countries in their efforts to align mental health systems and services delivery with international human rights standards" (World Health Organization, 2021, p. xvii). One of the initiative's key aims is "eliminating the use of coercive practices such as forced admission and forced treatment, as well as manual, physical or chemical restraint and seclusion" (World Health Organization, 2021, p. xviii). This represents a significant shift in the global mental health discourse, with a greater focus on addressing the social determinants of health, increasing human rights and a broader recovery focus (Cosgrove et al., 2020; World Health Organization, 2021).

The Guidance on Community Mental Health Services explores multiple areas of the mental health context and highlights innovative programs from around the world (World Health Organization, 2021). Of particular focus for the evaluation of these programs are several core principles and values:

- Respect for legal capacity.
- Non-coercive practices.
- Participation.
- Recovery approach

(World Health Organization, 2021).

There is a significant focus in the guidance module on peer support mental health services. As the World Health Organization (2021) states, "the services highlighted … are managed and run by people who are experts by experience" (p. 70). The promotion of lived experience was described in the Current Landscape as an exemplary method of recovery-oriented practice (see the Current Landscape: Lived Experience). Additionally, the creation of lived experience organisations was recommended as a future aspiration for the sector (see the Future Horizon: Recommendations). These program examples can provide a template and suggestions for the development of lived experience organisations and services in Australia. The technical package *Peer support mental health services: Promoting person-centred and rights-based approaches* (World Health Organization, 2021b), further supplements the information provided in the guidance modules.

The guidance module is extensive, and some highlights of the recommendations that are in alignment with this report at the sector and organisational level for community mental health providers are described below (World Health Organization, 2021).

Sector recommendations: Systems and Policy

- Engagement of citizens, including participation of people with lived experience in decision-making processes for policy making.
- Workforce development that includes training for recovery-oriented practice and human rights.
- Quality improvement and accreditation activities to safeguard human rights.
- Information and evaluation systems to inform quality improvement in the sector along with improving human rights.
- Role definition and delineation to ensure the support needs of people with mental health conditions and psychosocial disabilities.
- "Strengthening community understanding of mental health including through advocacy, combatting stigma and discrimination, and improving mental health literacy" (World Health Organization, 2021, p. 183).
- Development of community based mental health services networks

  (World Health Organization, 2021).

Organisational recommendations: Providers

- "Ensure services provide adequate support to families, carers and other support persons. And provide families, carers, and support persons with education, knowledge, and tools to support the recovery process" (World Health Organization, 2021, p. 190).
- Promotion of international human rights standards.
- Foster engagement of people with lived experience in the development and design of services.
- "Provide for independent advocacy services so that people using services can raise alarms or complaints about breaches of human rights or person-centred approaches, without fear of negative impact on their ongoing care" (World Health Organization, 2021, p. 191).
- "Ensure that services are available, accessible and culturally acceptable for all the individuals and groups of individuals" (World Health Organization, 2021, p. 191).

Recovery-Oriented Practice Training Updates

After the completion the Current Landscape and Future Horizon reports, additional training has been released. In this section, we add to the training programs that were recommended in the Future Horizon report (see section: Innovations and Training).

NDIS Psychosocial Disability Workforce Training

A recent training innovation developed by Ermha365 in partnership with Wodonga TAFE, MHV and Swinburne University utilises virtual reality (VR) to simulate practice scenarios to support the training of the psychosocial workforce in the NDIS (ermha365, n.d.). This training package is a part of the *Developing The Growing New NDIS (psychosocial disability) Workforce* Project (Mental Health Victoria, 2020). It seeks to fast-track student development, improve participant outcomes and the safety of both participants and workers. This training package will be rolled out across all Victorian TAFEs that offer Certificate IV in Disability, as well as to providers, so that it may be used during recruitment and embodies many ROP principles such as person-centred care and choice and control.

Further information:

Virtual Reality learning resources – Ermha365

MHV Psychosocial Learning Hub

Mental Health Victoria's national project to build ROPDS in the NDIS workforce across Australia offered a free Psychosocial Learning Hub course to up to 1000 people. This is funded by the Department of Social Services (DSS) as part of its Jobs and Market Fund. It was delivered over four weeks, and participants were able to complete one of the courses listed below:

Further information:

Fundamentals Of Psychosocial Disability and Mental Health Challenges – MHV Psychosocial Learning Hub
Establishing Recovery-Oriented Relationships – MHV Psychosocial Learning Hub

Foundations in Consumer Perspective Work

Athena Consulting has developed training for mental health workers delivered through the Centre for Mental Health Learning (CMHL) to provide a foundational overview of working with lived experience workers (Roper et al., 2021). The training covers three elements:

- History of the consumer movement.
- What is consumer perspective (the discipline)?
- What is the consumer workforce (the roles)?

(Roper et al., 2021).

The training outlines the history, principles and key concepts of the consumer movement, an introduction to the values, principles and ethics informing the consumer perspective and their practice application, and finally, the consumer workforce, exploring the ethical issues, debates, challenges and opportunities involved (Roper et al., 2021).

Further information:

Foundations in Consumer Perspective Work – CMHL Website

Financial Training for Participants and Workers

The Brotherhood of Saint Laurence provides services and education in assisting people to manage their finances through their Financial Empowerment & Resilience Network (FERN) (Brotherhood of St Laurence, n.d.-a). FERN provides workshops aimed at multiple financial skill levels, from basic budgeting to using financial services, understanding credit systems, and safeguarding from potential scams (Brotherhood of St Laurence, n.d.-a). Additionally, they provide training to community workers to increase their financial literacy skills to enable them to support their clients (Brotherhood of St Laurence, n.d.-b).

Further information:

Financial Empowerment & Resilience Network (FERN) – Brotherhood of St Laurence
MoneyMinded – Brotherhood of St Laurence

WHO QualityRights Training

The QualityRights Initiative provides fifteen different training modules and guides to assist organisations and workers in delivering mental health and psychosocial disability services with a human rights focus (World Health Organization, 2019a). In this section, we have highlighted two of the core modules; *Recovery practices for mental health and well-being* and *Recovery and the right to health*.

As described in the Current Landscape, the WHO QualityRights: *Recovery practices for mental health and well-being course guide* (2019c) provides a comprehensive training package for mental health workers in recovery-oriented practice. The learning outcomes are as follows:

- Gain an in-depth knowledge of the recovery approach to mental health care and its key principles and components.
- Understand and discuss the role of people with psychosocial disabilities, mental health and other practitioners, family, care partners and other supporters in promoting recovery.
- Develop recovery communication skills.
- Learn how to apply the principles of recovery-oriented care.
- Learn how to create a recovery plan.

  (World Health Organization, 2019c, p. xxvii).

The *Recovery and the right to health module* (World Health Organization, 2019b) provides a framework and training package for workers to assist with engaging in supports that promote physical health. The learning outcomes are as follows:

- Understand the concepts of mental health and well-being.
- Explore what mental health and related services can do to promote people's health and well-being.
- Understand the key components of, and barriers to, recovery.
- Develop an understanding of the role of mental health and related services in promoting and supporting health and recovery.
- Explore how individuals and services can respect, protect and fulfil people's right to health and recovery

  (World Health Organization, 2019b, p. xxvi).

Further information:

QualityRights materials for training, guidance and transformation – WHO QualityRights
Recovery practices for mental health and well-being – WHO QualityRights Core Training
Recovery and the right to health – WHO QualityRights Core Training

Recovery Promoting Competencies Toolkit

The Boston University Centre for Psychiatric Rehabilitation released a free toolkit for providers and organisations to develop their recovery orientation. The toolkit includes a self-assessment tool, an online course, and ROP strategies and resources (Farkas et al., 2016). The online course includes the following modules:

- Introductory; an introduction to recovery and ROP.
- Partnering; rapport, use of self and working in partnership.
- Inspiring; understanding the impacts of mental health conditions, sharing information, identifying personal meaning and building an alliance.
- Facilitating Choice; promoting choice and control, including helping consumers identify their decision-making criteria, clarify options, and systematic processes for decision-making.
- Teaching; this module is aimed at the organisation to assist in implementing ROP training (Farkas et al., 2016).

Further information:

Recovery Promoting Competencies Toolkit – Centre for Psychiatric Rehabilitation

Supported Decision-Making

Supported decision-making training for recovery coaches, which is also applicable to the psychosocial disability and mental health workforces, has been developed by the MHCC. Consisting of two modules, the training introduces supported decision-making, its history, why it is important, ethical and legal considerations, steps in the process, skills needed, and reflection on practice (Mental Health Coordinating Council, 2021c).

Further information:

Supported Decision-Making – MHCC

The Suicide Response Project

Researchers at the Olga Tennison Autism Research Centre (2021) have developed a website for the general community and practitioners to develop a framework and resources for responding to suicide (La Trobe University, 2021b). The suicide prevention initiative also includes information specifically to support people with autism spectrum disorder and from LGBTIQ+ identity groups. The framework is provided in twelve steps which describe the reasons for the resource, dealing with uncertainty, myths, risk factors, warning signs, interpreting risk and signs, how to help, responses and actions, decision-making and planning to respond, self-care and getting external help (La Trobe University, 2021a).

Further information:

The Suicide Response Project – Website

Mental Health Carers NSW Training

Mental Health Carers NSW as the peak body for carers of people with mental health conditions offers a number of online peer led psychoeducation and training programs (Mental Health Carers NSW, 2022). The training is designed for carers, however professionals (and others) are welcome to attend. The training packages have undergone a co-review or codesign process with mental health carers and are delivered by a carer peer (Mental Health Carers NSW, 2022). The training aims to building the wellbeing, capacity, and resilience of carers. Notably the training is provided at no cost. Particularly relevant to the ROPDS is training such as inclusive care planning and recovery-oriented practice (Mental Health Carers

NSW, 2022). The inclusive care planning module includes information such as the national standards for mental health services, rights, working collaboratively, open dialogue, and knowledge and resources to support people in care planning situations (Mental Health Carers NSW, 2022).

Further information:

Mental Health Carers NSW – Training Modules

NDIS Workforce Capability Framework

The NDIS Quality and Safeguards Commission (2021) has launched workforce capabilities for the whole NDIS workforce, which define core capabilities, additional capabilities for key priority groups and specialised support and organisational capabilities.

The NDIS Quality and Safeguards Commission Workforce Capability Framework (WCF) was commissioned by the Federal Government in 2019 as a result of the *Growing the NDIS Market and Workforce* plan (Commonwealth of Australia, 2019). The goal of the WCF is to develop nationally consistent guidance on expectations of the NDIS workforce aligned with the NDIS principles, Practice Standards, Code of Conduct, and relevant legislation (NDIS Quality and Safeguards Commission, 2021). It provides a single point of reference and is particularly important as many providers engage workers to deliver disability supports across a range of different areas.

Further information:

NDIS Workforce Capability Framework – Website

Core Capabilities

The capability framework is designed to be utilised by NDIS participants, workers, educators and trainers, supervisors and managers, and senior managers and leaders (NDIS Quality and Safeguards Commission, 2021). The core capabilities are developed by the level of the support role, e.g. general, advanced and ancillary, building and expanding at each level (NDIS Quality and Safeguards Commission, 2021). Additional capabilities for specific roles and key priority groups are then added to the core capabilities. The core capability domains are summarised below and specified for psychosocial disability, as shown in Table 1.

Our Relationship

The capabilities for Our Relationship are focused on the relationship between NDIS participants and the worker. This includes capabilities related to rights, communication, building and maintaining relationships, and working collaboratively (NDIS Quality and Safeguards Commission, 2021).

Your Impact

Your Impact is focused on professional development, role and impact. The capabilities focus on reflection and self-awareness, working within scope and knowing your role, and self-care (NDIS Quality and Safeguards Commission, 2021).

Support Me

The Support Me capabilities involve understanding the needs, interests, and values of the NDIS participant. The capabilities include gaining an understanding of what a ‘good life’ looks like for the NDIS participant, supported decision-making, and building capacity for social participation (NDIS Quality and Safeguards Commission, 2021).

Be Present

The section Be Present correlates to capabilities focused on responding to the person and being flexible, managing health and safety, and engagement and motivation (NDIS Quality and Safeguards Commission, 2021).

Check In

Checking in involves evaluating the efficacy of current supports. The capabilities are to review the quality of supports and support NDIS participants to engage in feedback and complaints (NDIS Quality and Safeguards Commission, 2021).

NDIS Psychosocial Disability Capabilities and ROPDS

In this section, the NDIS Psychosocial Disability Capabilities (PDC) from the NDIS Workforce Capability Framework has been compared with the ROPDS Capability Framework from the Future Horizon report. What we demonstrate in Table 1 below is how the capabilities are linked to the practice perspectives that we have identified in our investigation of ROP. Finally, in the findings after Table 1, the team has identified any gaps or differences with recovery-oriented practice principles and values.

We acknowledge that the *NDIS Quality and Safeguards Commission Workforce Capability Framework* or guidance on specific aspects or types of support, such as the Psychosocial Disability Capabilities (PDC), are intended to be complementary to the WCF core capabilities, enabling users to get more detailed guidance in a particular area.

The ROPDS capabilities presented in this report offer more specialist guidance for recovery-oriented psychosocial disability practice, and we intend to illustrate here how the general guidance within the NDIS WCF applies when providing more specific support. For example, in addition to the specialised capabilities, the NDIS WCF organisational capabilities section describes supervisory and leadership capabilities that apply across all types of support (NDIS Quality and Safeguards Commission, 2021). This more specialised guide may assist psychosocial disability support providers and organisations to interpret the expectations of the WCF. For example, the following capabilities from the section; Manage, supervise and coach others: “Provide opportunities for workers to reflect on their practice, debrief about challenging situations or events, and share learnings with supervisors, peers and experts, including people with lived experience” (NDIS Quality and Safeguards Commission, 2021, p. 185). Or have knowledge of: "Current and emerging best practice models and frameworks in disability and related services” (NDIS Quality and Safeguards Commission, 2021).

TABLE 1: COMPARISON OF NDIS PSYCHOSOCIAL DISABILITY CAPABILITIES WITH ROPDS CAPABILITIES.

Please note the NDIS Psychosocial Disability Capabilities has been reproduced as written in the NDIS Capability Framework (NDIS Quality and Safeguards Commission, 2021, p. 157).

	NDIS Quality and Safeguards Commission Psychosocial Disability Capabilities:	Practice Perspectives
	Our Relationship	
	What you do and how you do it	
1	Be persistent and patient in building our relationship at my chosen pace.	Person-centred/ Social and relational
2	Learn how my psychosocial disability affects my functioning, mood, behaviour, my relationships, environment, and circumstances.	Person-centred
3	Recognise and build the capacity of my family and informal networks to support my recovery.	Social and relational
4	Engage my support team to build a shared understanding of recovery-oriented practice.	Lived experience
	What you know	
5	The stigma, discrimination and exclusion that may be experienced by people who require mental health support.	Social determinants/ Human rights
6	The personal, clinical and functional dimensions of recovery.	Recovery knowledge/ MH knowledge
7	Common signs and symptoms of mental health issues, and the potential impact on work, family and social relationships.	MH knowledge
8	The episodic nature of psychosocial disability and potential impact on energy levels, emotions, physical and mental health, ability to concentrate, think clearly and communicate.	Supporting personal recovery/ MH knowledge
9	Personal and environmental factors that commonly influence behaviour and add to complexity including experiencing trauma, drug or alcohol dependence, unstable work and housing, involvement with the justice system.	Trauma informed/ Social determinants

10	Strategies to actively engage and build relationships with vulnerable participants such as people who are disengaged or who need support to process information and express their views.	Person-centred/ Social and relational
11	Decision-making authority of members of the support team and the circumstances in which this authority can be exercised if a participant is not able to make or express their decision.	Substitute decision-making
12	The roles of related sectors, programs and agencies that support people with psychosocial disability such as housing, drug and alcohol, employment support, health and advocacy and peer organisations.	Social determinants/ Lived experience/ Social and relational/ Citizenship
	Your Impact	
	What you do and how you do it	
13	Observe and be aware of how your attitudes, language, and behaviours can affect me and trigger reactions.	Trauma-informed/ Person-Centred
14	Think about your own attitudes, language and behaviours and how well they are aligned with recovery-oriented practice.	Supporting personal recovery
15	Assess your capacity and confidence to provide the support I need and seek support to maintain your resilience and wellbeing.	Recovery-oriented supervision/ Org. capabilities
16	Look for and recognise any signs you may be experiencing vicarious trauma and seek appropriate support to manage it.	Trauma-informed/ Recovery-oriented supervision/ Org. capabilities
17	Participate in and contribute to practice coaching and practice supervision.	Supporting personal recovery/ Recovery-oriented supervision/ Org. capabilities
	What you know	
18	Scope of responsibilities for providing psychosocial support, including the roles of recovery coaches, support and peer workers.	Knowledge of NDIS/ Coordination
19	How to apply current best practice tools, approaches and expectations about psychosocial disability, and recovery-oriented and trauma-informed approaches, principles and language.	Evidence informed/ Recovery-oriented supervision
20	Understanding of how the mental health system and related services intersect with the NDIS.	Communication, collaboration and coordination/ MH and NDIS knowledge
21	Behaviours or practices that do not support recovery-oriented practice, such as poor or inconsistent understanding of interpersonal boundaries and poor or inadequate self-care.	Supervision/ MH knowledge
22	Causes and signs of vicarious trauma where workers themselves experience trauma because of what they see or hear about.	Trauma-informed/ MH knowledge
	Support Me	
	What you do and how you do it	
23	Explore how my experience of psychosocial disability affects my capacity and confidence to function, make decisions and adjust your approach to suit my needs and pace.	Person-centred/ Supporting personal recovery
24	Support me to identify my strengths, capacity and resources to build my coping skills and motivation. Support me to expand my vision for my recovery.	Person-centred/ WHO QRF/ CRM/ REFOCUS/PULSAR
25	Support me to make connections, find information, and explore my options to access paid and informal supports.	Social and relational/ Social determinants
26	Work with me to choose and use approaches that build my resilience and wellbeing as I work on my recovery.	Supporting personal recovery
27	Work with me to identify solutions and address barriers within and across service providers, programs, service systems and sectors.	Human rights/ Social determinants
28	Encourage me and my other service providers to recognise and challenge prejudice or lack of vision in service offerings and attitudes.	Human rights/ Social and relational/ Social determinants
29	Support me to maintain and strengthen the capacity and resilience of my family and/or social networks to provide a supportive and inclusive environment.	Social and relational

30	Work with me and my support team to develop a shared understanding of how to respond to emergencies, crises and foreseeable life events.	Responding to emotional distress/ Trauma-informed
	What you know	
31	Strategies to build confidence to make decisions, including use of advocates, peer support and supported decision-making.	Person-centred/ Human rights/ Lived experience
32	Recovery-oriented service providers and systems, networks, resources, and referral pathways.	Knowledge of MH/ Communication, Collaboration and Coordination
33	Early intervention options.	Knowledge of MH and NDIS/ Coordination
34	The importance of personal and community relationships in a participant's recovery journey.	Social and relational/ Citizenship
	Be Present	
	What you do and how you do it	
35	Recognise that my need for support or assistance is likely to fluctuate and adapt support to suit what I need.	Knowledge of MH/ coordination
36	Maintain and build my capacity and confidence to persist with and track my recovery journey and to cope when things are not going well.	Coaching/ Person-centred
37	Explore reasons that can cause me to withdraw and find ways to motivate me to engage.	Knowledge of MH/ Person-centred/ Coaching
38	Be alert to experiences or circumstances that I find distressing or that refresh trauma and support me to use strategies or access environments so I feel safe.	Trauma-informed
39	Support me to use constructive techniques to regulate or de-escalate my mood, emotions or behaviours and reduce potential harm.	Trauma-informed/ Responding to emotional distress
40	Recognise and respond when my mental health or behaviours present risks to me and/or others.	Risk management/ Coordination
	What you know	
41	The purpose of providing psychosocial support to aid recovery and risks and consequences of not providing planned support.	Supporting personal recovery/ Coordination
42	Strategies and techniques for coaching and motivating.	CRM/ WHO QRF/ PULSAR/REFOCUS/ Intentional Peer Support/ Supervision
43	Personal and environmental factors likely to influence mood, emotions and behaviours, including those that trigger or reinforce unwanted patterns of thinking or behaviour.	Cognitive behavioural therapy/ Supporting personal recovery
44	Strategies and techniques to regulate and de-escalate mood, emotions or behaviours, including positive behaviour support strategies.	Trauma-informed/ Responding to emotional distress
45	When and how to escalate and respond to complex situations that can arise from emergencies or crises.	Risk management/ Coordination
46	Self-harm and suicide risk interventions and supports.	Responding to emotional distress/ Coordination
47	Agencies and experts that partner in supporting recovery.	Collaboration, Communication and Coordination
48	Reporting responsibilities, including recording observations and incident reporting.	Risk management/ NDIS capabilities
	Check In	
	What you do and how you do it	
49	Support me to reflect on and review my recovery process in ways that are meaningful and relevant to me.	Person-centred/ supporting personal recovery
50	Partner with me in collecting and reviewing information about my supports and how well they are meeting my needs.	Evidence informed/ Human rights

51	Support me to identify opportunities for increased independence and reduced reliance on service systems where this is possible and at my own pace.	Knowledge of NDIS
52	Support me to find and access safe channels that I am comfortable with to raise concerns, complaints, and incidents when they arise.	Human rights/ Citizenship
	What you know	
53	The role of workers and coaches in contributing to the evaluation of recovery plans.	Evidence informed/ Knowledge of NDIS

Capabilities: Discussion and Findings

In considering the PDCs alongside the ROPDS literature, we found that many of the capabilities are strongly aligned with practice perspectives and principles. For example, capability 14: "Think about your own attitudes, language and behaviours and how well they are aligned with recovery-oriented practice" (NDIS Quality and Safeguards Commission, 2021, p. 159). However, some differences were identified in the use of language, competing perspectives and the most relevant (or useful) practice approach.

Some areas of language used in the PDCs seemed more consistent with a clinical approach rather than ROP (e.g., capability 9 and 43) or emphasised risk management in a way that appeared inconsistent with the language of ROP (e.g., capability 45 and 48). These contrasted with other capabilities that utilised recovery-oriented language, such as in capability 49: "support me to reflect on and review my recovery process in ways that are meaningful and relevant to me" (NDIS Quality and Safeguards Commission, 2021, p. 165).

Similarly, the capabilities reflect shifts between different perspectives that are not always consistent with a recovery approach. For example, capability 9: "personal and environmental factors that commonly influence behaviour and add to complexity including experiencing trauma, drug or alcohol dependence, unstable work and housing, involvement with the justice system" (NDIS Quality and Safeguards Commission, 2021, p. 158). In this capability, several factors are listed (trauma, substance use, insecure work and housing and justice system involvement); a social determinants lens may not describe these as 'personal factors' instead view them as impacts of social exclusion (Allen et al., 2014). We suggest the term 'social factors' better encapsulate their standing as social determinants and structural impacts. Additionally, in capability 9, by framing the 'problem' as 'impacts behaviour' and 'adding to complexity', the challenging experience of these social circumstances and structural factors may be overlooked. Whilst the statement implied in the capability is accurate, the approach may not consider the underlying intersectional impacts of these factors.

In the PDCs, because some of the capabilities are focused on the worker or participant rather than the social and structural factors, an individualist approach to practice may be encouraged. In contrast, ROP encourages a more balanced approach that sees the person in their environment. A structural approach may account for factors such as intersectionality, social determinants, and human rights. However, several capabilities were well-grounded in these approaches (e.g., 5, 25, 27, 31, 34). Capability 5, for example, encouraged workers to understand the role and impact of stigma and discrimination on participants with a psychosocial disability. The inclusion of a human rights and social determinants approach to ROP also requires support and implementation at an organisational level. As highlighted in the organisational capabilities and enablers for ROPDS, the efficacy of ROP is facilitated through the recognition of the responsibility of the organisation to support and foster recovery practice at all levels (see Current Landscape and Future Horizon).

Another critical interpretation is enabled when reflecting on some of the PDCs that appear to be more goal-driven rather than focused on flourishing. For example, capability 36: "Maintain and build my capacity and confidence to persist with and track my recovery journey and to cope when things are not going well" (NDIS Quality and Safeguards Commission, 2021, p. 163). This capability can represent an understanding of recovery as a destination, as opposed to recovery as a process. Conversely, capability 49 demonstrates a more nuanced and less goal-driven approach: "support me to reflect on and review my recovery process in ways that are meaningful and relevant to me" (NDIS Quality and Safeguards Commission, 2021, p. 165).

Another capability that can be interpreted differently depending on the practice approach is capability 51: "Support me to identify opportunities for increased independence and reduced reliance on service systems where this is possible and at my own pace" (NDIS Quality and Safeguards Commission, 2021). This capability reflects the differences that can emerge between the NDIS and the implementation of the recovery paradigms. As Slade et al. (2014) state in their article *Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems*, "recovery is not about 'getting better' or ceasing to need support – it is about 'recovering a life', the right to participate in all facets of civic and economic life as an equal citizen" (p. 14). NDIS supports that seek to empower participants to choose to reduce their reliance or involvement with service systems may be an excellent demonstration of promoting citizenship and recovery. However, as reflected by Slade et al. (2014), it is important to safeguard the principles of the NDIS and ensure that participants being in recovery is not synonymous with having their plan funding reduced.

ROP and Substitute Decision-Making

There are capabilities in the PDC that strongly demonstrate the intersection between the NDIS practice standards, legislation, and the current realities of practice, such as the continued use of substitute decision-making. This represents challenges for fully embedding ROP in future NDIS practice. For example, capability 11: "Decision-making authority of members of the support team and the circumstances in which this authority can be exercised if a participant is not able to make or express their decision" (NDIS Quality and Safeguards Commission, 2021, p. 158). This capability reflects practice in the presence of a substitute decision-maker, which may be in place for some NDIS participants such as in the circumstances of a treatment or guardianship order. However, with a recovery orientation, a supported decision-making approach is advocated on the basis that people should be supported to the extent necessary to make their own decisions, or at the very least have significant input. Conversely, capability 31, promotes a supported decision-making approach.

As discussed earlier in this report, the use of substitute decision-making has particular implications for NDIS participants who are also under a compulsory treatment order, or guardianship and administration order (see section: Financial Supports and Administration, pp. 9-10). As aforementioned, since the introduction of the NDIS, applications for guardianship and administration orders by NDIS providers has significantly increased (Australian Law Reform Commission, 2014; Office of the Public Guardian, 2017). Similarly, the use of community treatment orders (CTO) face scrutiny both internationally (Rugkåsa, 2016) and in Australia (Light et al., 2012). Notably, there are increasing calls to shift the current model in mental health away from substitute decision-making to a supported and shared decision-making model (Davidson et al., 2016; Sugiura et al., 2020).

In the presence of CTOs, participants experience significant challenges to their autonomy and self-determination (Edan et al., 2019; VMIAC, n.d.). In research emerging from the PULSAR project, implementation and uptake of ROP were found to be impeded in the presence of CTOs (Edan et al., 2019). The effect of being on a CTO for consumers was also discussed. As Edan et al. (2019) state, "for consumers being on a CTO meant lacking choice and control, an emphasis on medication, fear of the threat of hospitalisation, an absence of recovery-oriented practice, and staying supported" (p. 178). The impact of CTOs on ROP in care planning in mental health services was found to contribute to multiple challenges for consumers, including the emphasis on risk, mismatch of issues and goals, minimising consumer concerns, clinician leading decision-making, persuasion and coercion, and lack of trust (Dawson, 2021). Notably, Edan et al. (2019, p. 182) highlighted the "importance of organisational support to effect change in practice." Despite the challenges, ROP with participants who are on a treatment order can be achieved.

An ROP approach with participants in these circumstances may involve utilising recovery principles and knowledge from human rights based approaches and structural competency. This may include ensuring to acknowledge the participants' feelings and concerns (Hansen et al., 2018; Topor et al., 2018), understanding their preferences, goals and aspirations, promoting choice and control, citizenship and self-determination (Dawson, 2021; Slade et al., 2014), utilising techniques such as supported decision-making (Bauer et al., 2019) and empowering them through advocacy and self-advocacy (Rowe & Davidson, 2016; World Health Organization, 2021). As Davidson et al. (2016, p. 163) stated, "good practice in focusing on recovery and supported decision-making needs to start with really listening and responding to what service users say they need and represents the least harmful approach for all."

National Codesign Workshops and ROPDS

In 2021, Mental Health Victoria (MHV) conducted the National Codesign Workshops series as a part of the *NDIS Recovery-Oriented Psychosocial Delivery Support Project: Growing National Workforce Capability*. The workshops aimed to explore the experiences of people receiving and delivering NDIS psychosocial supports and how recovery-oriented practice could best be delivered (Mental Health Victoria, 2021a, 2021b). MHV released two reports of the findings from the National Codesign Workshops:

- Thoughts and Experiences about NDIS Psychosocial Support: Participant and Carer Feedback, National Codesign Workshop Series (Phase 1).
- Thoughts and Experiences of the Psychosocial Workforce: NDIS Provider and Worker Feedback, National Codesign Workshop Series (Phase 2).

Methodology

In this chapter, the Phase 1 and Phase 2 National Codesign Workshop report findings are compared and synthesised with the findings from the Current Landscape and Future Horizon reports. The Phase 1 report focuses on NDIS participants with a psychosocial disability and their carers. The Phase 2 report focuses on NDIS providers and NDIS workers who provide psychosocial disability support. Drawing from the insights developed during these two phases, and the current barriers, the challenges of delivering recovery-oriented practice can be identified. The Current Landscape reported on enablers of recovery-oriented practice, while this report aims to explore the gaps, barriers, and challenges. Arising from these project aims are the following research questions:

- What are the challenges and barriers to recovery-oriented practice?
- Are there unmet psychosocial support needs?

Due to the previously reported dearth of recovery-oriented practice literature for the NDIS context, the following questions were added:

- Are there gaps in the literature?
- What do the findings add to the literature?

In this chapter the report first describes the National Codesign Workshops, then explores the findings in each of the following domains of recovery-oriented practice: person-centred, supporting personal recovery, social inclusion and social determinants, and collaboration, communication, and coordination. The barriers to recovery oriented psychosocial disability support identified in the National Codesign Workshop reports are then integrated with findings from the Current Landscape and Future Horizon Reports to suggest the implications for future practice.

Phase 1: NDIS Participant and Carer Workshops

The Phase 1 report, *Thoughts and Experiences About NDIS Psychosocial Support: Participant and Carer Feedback, National Codesign Workshop Series* (Lived Experience Workshop Report) by Mental Health Victoria (2021a), provides insights into the current on-the-ground experiences of NDIS participants with a psychosocial disability and their carers.

The Lived Experience Workshop Report details the findings from the 19 workshops conducted by lived experience facilitators from MHV and partner organisations across Australia in each state and territory, including rural areas. The workshops were attended by 160 people who are participants of the NDIS receiving psychosocial disability support, and their carers. Of the 19 workshops, seven were with NDIS participants, eight with carers and four with both NDIS participants and carers. Subsequently, the NDIS participant and carer input was synthesised together, so this report is unable to identify if quotes were obtained from NDIS participants or carers and should be interpreted accordingly. For the purposes of

this report, the NDIS participant and carer workshop attendees are referred to as Lived Experience Workshop Participants.

Phase 2: NDIS Worker and Provider Workshops

In the second phase of the National Codesign Workshop Series, MHV conducted online surveys with NDIS workers and providers who deliver psychosocial disability supports. The survey received 200 responses, and participants were invited to attend workshops. MHV conducted six workshops, four with NDIS workers, and two with representatives from NDIS provider organisations.

The four workshops with NDIS workers were attended by 45 frontline NDIS workers who provide support to NDIS participants with a psychosocial disability and their carers. Roles held by the workers included support workers, peer support workers, recovery coaches and support coordinators. Notably, a mix of workers attended the sessions, which included those from organisations and sole traders.

In the Provider Workshops, two workshops were conducted with 36 leaders and supervisors from NDIS provider organisations. The providers included organisations that offer NDIS psychosocial support services, operating in metropolitan, regional and rural areas. The organisations had varying origins and auspices from across the sector. This includes:

- National community mental health providers, formerly specialist mental health service providers.
- Organisations who had initially specialised in aged and disability support services
- Start-up NDIS providers.
- Peer led/managed organisations
  (Mental Health Victoria, 2021b, p. 10).

The organisations included providers who work with diverse communities, including Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse, and LGBTIQ+ communities. The Providers also identified if they supported NDIS participants with dual disability or complex support needs, dual diagnosis, and experience of homelessness.

For the purposes of this report, the NDIS provider workshops attendees are referred to as Provider Participants and the NDIS Workers and sole providers are referred to as Workers.

Further Information:

NDIS ROPDS Project: Growing National Workforce Capability – MHV Project Webpage
Participant and Carer Feedback, National Codesign Workshop Series (Phase 1) – Report Link
NDIS Provider and Worker Feedback, National Codesign Workshop Series (Phase 2) – Report Link

Revisiting the 'Good' Worker

In the Current Landscape report, the findings from the paper *People making choices: the support needs and preferences of people with psychosocial disability* (Brophy et al., 2014) was reported utilising the 'good' worker diagram. In this research, conducted in anticipation of the NDIS commencement, participants with a psychosocial disability described what supports they would need from the NDIS and their ideal support worker, which they described as a "good worker" (Brophy et al., 2014) . In the Phase 1 and 2 reports the elements of an ideal recovery-oriented psychosocial disability support worker were explored and the findings reported in several word clouds (Mental Health Victoria, 2021a, 2021b). Figure 3 shows the top five responses for each category of support work by the Lived Experience Workshop participants:

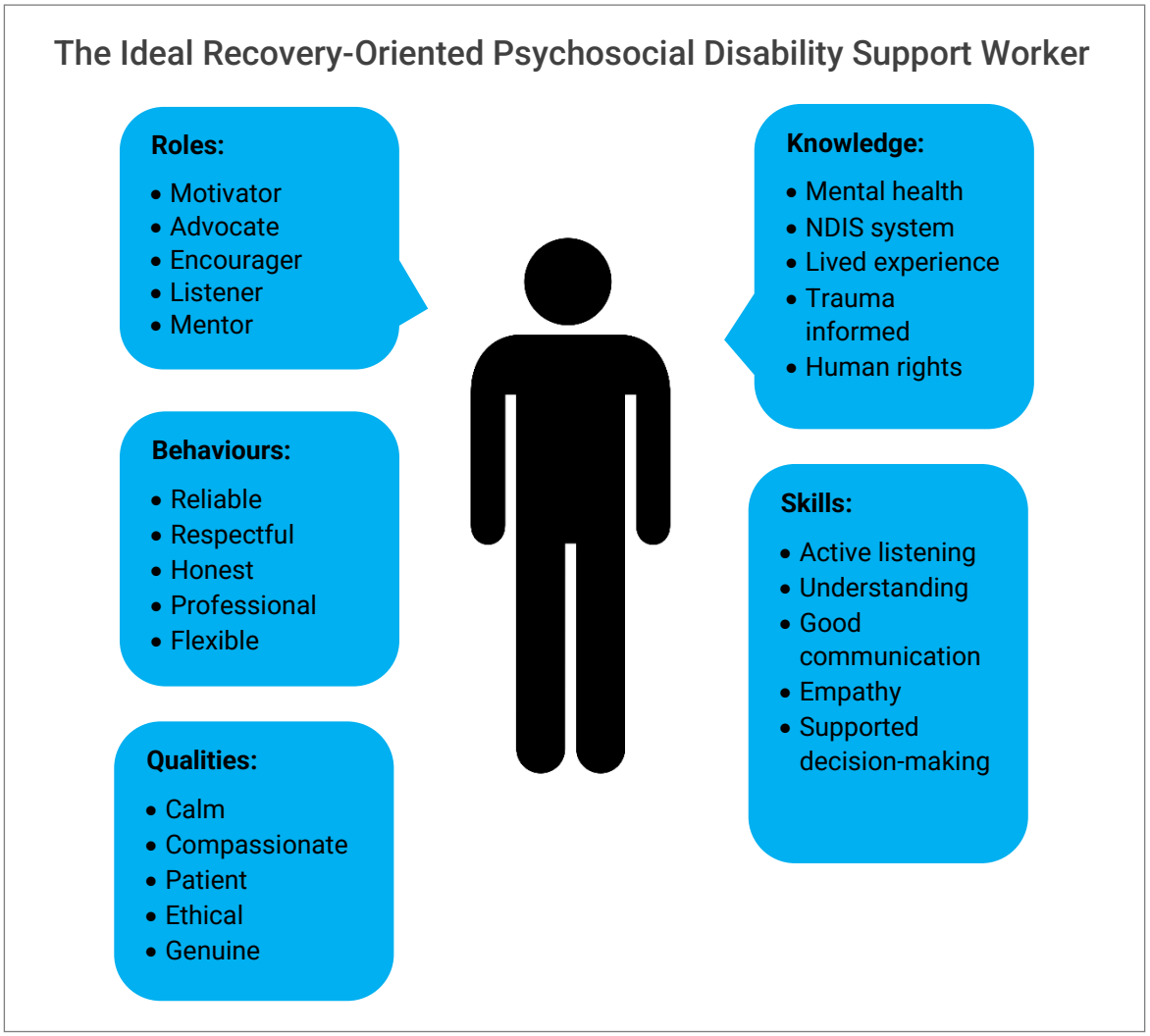

FIGURE 3: ASPECTS OF AN IDEAL ROPDS WORKER.

As reported by Lived Experience Workshop Participants (Mental Health Victoria, 2021a, pp. 8-13).

In comparing Figure 3 with "a 'good' support person (Brophy et al., 2014) there is significant overlap and similarity between the two. However, the role of educator was not listed by Lived Experience Workshop participants. There were also numerous additional elements described in the Phase 1 report. Some of these included specific practical skills and knowledge such as technology, meditation, supported decision-making, cardiopulmonary resuscitation (CPR), creative/art skills, de-escalation, CALD interpreter, local/geographical knowledge, and nutrition (Mental Health Victoria, 2021a). The Lived Experience Workshop participants also described behaviours and qualities such as coaching, coordinator, entertainer, humorous, companion, time-management, community includer, and participant and carer participation (Mental Health Victoria, 2021a).

In the Provider and Worker Report, workers from the NDIS psychosocial disability context discussed good practice in ROPDS, which was reported in a word cloud (see Figure 4 below).

FIGURE 4: GOOD RECOVERY-ORIENTED PRACITCE

As described by NDIS psychosocial disability workers in the Phase 2 report (Mental Health Victoria, 2021b, p. 17).

The most commonly used words and phrases for ROPDS included respect, choice, participant led/person-centred, goals, support, hope, listen and collaborative (Mental Health Victoria, 2021b, p. 17).

Barriers to Recovery-Oriented Practice by Domain

In the Phase 1 and Phase 2 National Codesign Workshop reports (Mental Health Victoria, 2021a, 2021b), the Lived Experience Workshop Participants and Worker and Provider Workshop Participants described the challenges and barriers that they have experienced in the NDIS context. Despite the challenges, both the Lived Experience Workshop and Worker and Provider Workshop attendees recognised the opportunities for NDIS recovery-oriented psychosocial disability support. A Lived Experience Workshop participant describes the future of the NDIS as: *"looking forward to something bright in the future. Possibilities are endless. But it's an awful journey to get there"* (Mental Health Victoria, 2021a, p. 34).

A whole of system approach for changes in the sector was discussed: *"can you have good support without a good support worker, I don't think you can. But you also need a good provider and system to get that good support worker"* (Mental Health Victoria, 2021a, p. 14).

Recovery-Oriented Practice Workforce Capability Domains

As depicted in the Future Horizon report, recovery-oriented psychosocial disability support workforce capabilities can be expressed through four domains: person-centred, supporting personal recovery, social inclusion and social determinants, and collaboration, communication, and coordination (see Figure 5).

The recovery-oriented domains have been utilised to explore the findings from the Lived Experience Workshop and Provider and Worker reports. Notably, as described in the Future Horizon, these domains are not discrete categories, they intersect and overlap with other domains of recovery-oriented practice. Subsequently, the barriers in this report may also align with other domains of recovery-oriented practice.

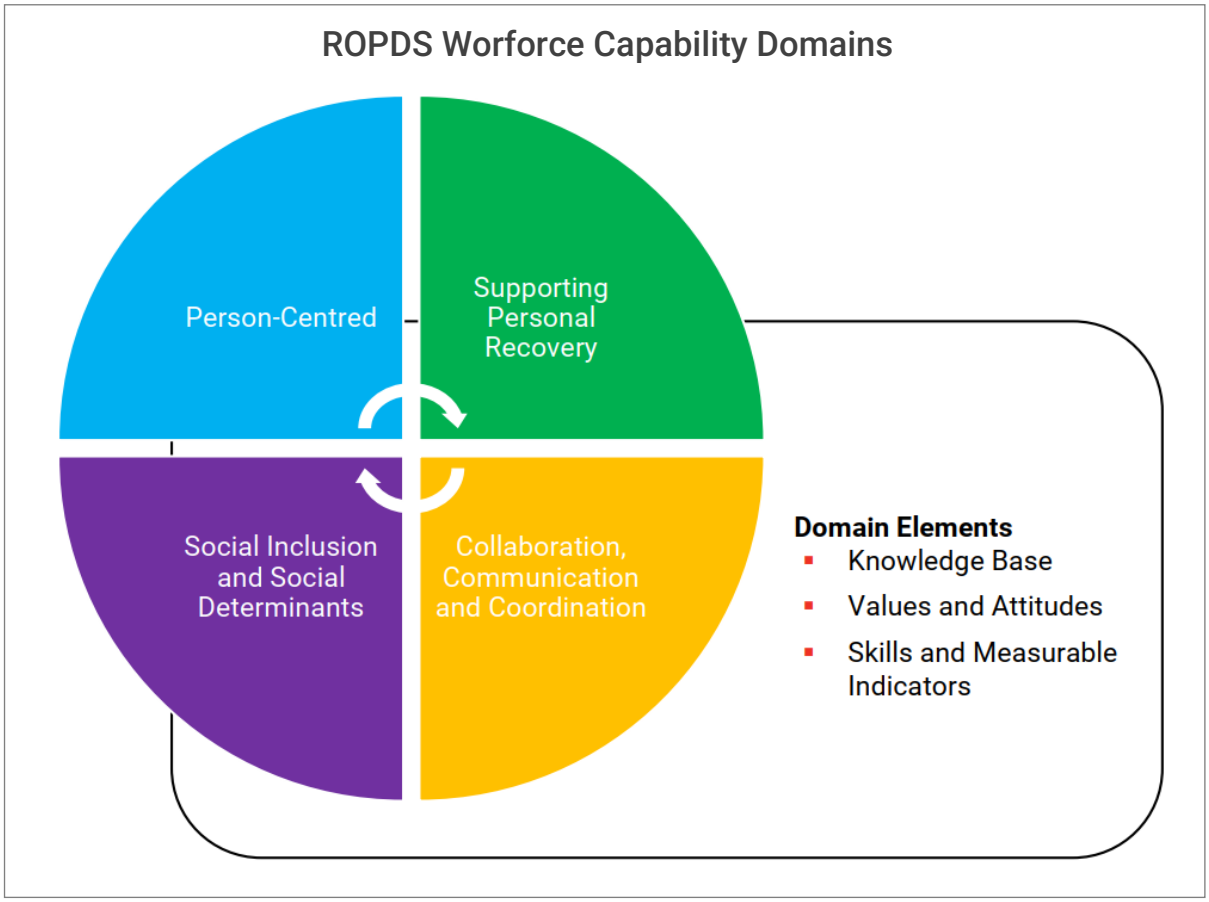

FIGURE 5: RECOVERY-ORIENTED PSYCHOSOCIAL DISABILITY SUPPORT WORKFORCE CAPABILITY DOMAINS

From The Future Horizon, Brophy et al. (2021b, p. 36).

Barriers to Person-Centred Support

The feedback from NDIS participants and carers from the Lived Experience Workshop Report highlights the importance of person-centred approaches. Participants communicated that person-centred knowledge and skills are essential across sectors including the health and medical, mental health and disability contexts. As stated by Mental Health Victoria in the section, *Helping match me with workers that will meet my needs: "there was strong feeling from the feedback [from Lived Experience Workshop participants] that a 'one size fits all' approach is not appropriate when considering individual interests, needs and life experience is vital"* (2021a, p. 23).

Further, a Lived Experience Workshop participant stated, *"workers have an assumption that 'I've worked with someone like that before so I know how to do it', but everyone is different. Not everyone is the same and no one visit is the same"* (Mental Health Victoria, 2021a, p. 32).

Interpersonal Skills and Rapport

The Lived Experience Workshop participants discussed the need for their support workers to have high levels of interpersonal and communication skills in order to facilitate the relationship with the NDIS participant and their carer/s. One participant said: *"I need people that are paying attention to subtle changes and will adjust how they are behaving or supporting, and this is quite a high-level interpersonal skill"* (Mental Health Victoria, 2021a, p. 35). As an NDIS worker states *"look to the person to look what will work for them in terms of communication style, how often they want us to check in with them, really look to them"* (Mental Health Victoria, 2021a, p. 18). Rapport, communication, and active listening were highly valued by the Lived Experience workshop participants. *"Listen – How can you be an effective everything if you don't listen. It's an inherent function – if you want to talk you got to listen. Someone who's aware they don't have to solve my issues, just walk with me"* (Mental Health Victoria, 2021a, p. 35). Being non-judgemental and respectful was also highly valued by the workshop participants.

Challenges with support workers was also raised. In particular, some support workers appearing to be disengaged or unmotivated in their role was noted e.g. workshop participants describe their support workers focusing on their phones, belongings or paperwork instead of the participant (Mental Health Victoria, 2021a). As a Lived Experience Workshop participant expressed: *"Good strong onboarding process to manage support worker understandings of what is expected of them during a shift – they are there to pay attention to the participant, not be on their phones, and doing personal stuff during shift time. Some of them couldn't care less"* (Mental Health Victoria, 2021a, p. 22). Notably, this was the exception not the norm in the responses, however it highlights some of the implications for NDIS participants and carers such as feedback processes and choice of worker.

Low Expectations and Stigma

In the National Codesign Workshops Phase 1 report, feedback from NDIS participants and their carers highlighted that they felt impacted by support workers low expectations and stigmatising behaviours. One Lived Experience Workshop participant described the need for support workers to *"have curiosity about the person, showing interest and seeking new ideas. Be non-judgmental – bias and stigma need to be contained"* (Mental Health Victoria, 2021a, p. 32). Further, it was reported that *"they seek persistent approaches and request that providers don't develop low expectations of the participant… an enabling environment where the worker is confident that they and the participant can make decisions together is important"* (Mental Health Victoria, 2021a, p. 25). Participants reported that they would like to feel seen, heard and understood as an individual. As Mental Health Victoria state:

> Seeing the individuality of the person and respecting their own 'self-care' strategies and personal needs was viewed by participants as a fundamental behaviour for workers to possess. This was expressed as an essential component to understanding the whole person and included accepting the NDIS participants 'quirks', goals and life experience without judgement or bias. Showing curiosity and trusting in the individual to be the expert in their own care and life was one way in which participants felt their uniqueness and individuality could be reflected" (2021a, p. 32).

Retention and Recruitment

A leading challenge from both the Phase 1 and 2 reports emerges from the NDIS workforce issues that have been largely reported elsewhere such as shortages, thin markets and casualisation (National Disability Services, 2019; Productivity Commission, 2020; VMIAC, 2020; Wilson et al., 2021). Notably, this is a known issue for the NDIS sector more broadly, and it has a significant impact on recovery-oriented practice. As a Lived Experience Workshop Participant states *"… consistency is more important than flexibility. Have to repeat the story to every new person, go through inner discomfort and bond building time."* (Mental Health Victoria, 2021a, p. 22). One carer from the workshops describes the impact on the workers themselves:

> Staff workload management is a high priority – why? Work smarter not harder. We don't want workers to burn out, change over every six months. As carers we are talking about management, we don't sit in that stream, the fact that everybody has mentioned it means we can see what is going on higher up, you wouldn't assume that we would be talking about workload and staff and management. It flows down. It is reflected in the turnover you face with support workers. You get used to one person and then they move on. We need consistency. What affects one affects everybody… (Mental Health Victoria, 2021a, p. 26).

This impact of the workforce transience on the relationship and trust is described by a Lived Experience Workshop attendee: *"…Amazing support worker has developed trust – coordinators and allied health assistant roles keep changing. Hard for consumer due to trust – very hard to start new relationships and activities…"* (Mental Health Victoria, 2021a, p. 40).

Recruitment is another area that creates challenges, *"if you are going to have a good service you need to have a very stringent recruitment strategy, you have to recruit exactly the right people, not just hire people. Very particular personal qualities"* (Mental Health Victoria, 2021a, p. 13). However, in the NDIS context recruitment and retention are ongoing issues for providers. As described in the Provider Workshops, *"…issues when staff move on or leave. Lack of job security doesn't help with that at all. And breaking trust/abandonment/let down when staff member leaves can add to trauma/issues. Need a backup of people they know like and trust, but staff shortages make that really difficult. Finding the staff that tick those boxes of what/who the person relates to. Shadow worker/two-worker model is ideal if you can have that extra, but hard to get and find that staff."* (Mental Health Victoria, 2021b, p. 14).

Knowledge of NDIS Participant and Carer Information

As reported in the Phase 1 report (Mental Health Victoria, 2021a), NDIS participants and their carers highlighted examples of systems and processes within the organisation which created barriers for support workers gaining access to appropriate information about the participant. Various barriers to information sharing were described, from poor communication systems, to design faults in software, to a lack of time for support workers, inter-agency communication challenges, and others.

Due to the time pressures and limitations as a result of the fee-for-service model, NDIS workers need access to sufficient information about the NDIS participant and their families. This information on goals, support needs, health concerns, family dynamics, and other areas is extensively gathered as a part of the NDIS process. It places an unnecessary burden on the NDIS participant and their carers to have to repeatedly relay this. As Mental Health Victoria reports, Lived Experience Workshop participants recommended that *"workers be given time and information that helps them understand the needs of individuals and this will help to build trusting, effective and transparent support relationships"* (2021a, p. 25). A lack of knowledge and information about the participant and their coexisting disability and/or health needs was also discussed. *"Participants reported that often workers don't know what other disabilities they have i.e. vision/hearing, and sometimes don't know what else is in the NDIS plan*" (Mental Health Victoria, 2021a, p. 26).

Barriers to Supporting Personal Recovery

In the domain of supporting personal recovery several elements were discussed. Notably, the importance of a whole-of-organisation adoption of recovery values and principles. As a Lived Experience Workshop participant describes *"organisations being committed to recovery principles, this is reflected in*

how they treat people, how they train staff, the way they recruit people, vision and mission of the organisation" (Mental Health Victoria, 2021a, p. 22).

The Lived Experience Workshop participants valued choice and control as a key element to their recovery. For example, as one participant *stated "gives you choices, not decide for you. Don't expect the right choice the first time. My choice might change, nothing is set in stone"* (Mental Health Victoria, 2021a, p. 32).

Understanding Mental Health, Recovery and Responding to Distress

The feedback from the participants in the National Codesign Workshop Phase 1 and 2 reports described the knowledge, skills and values about mental health and personal recovery that are needed to work in the psychosocial disability context. As a worker states in the Phase 2 report *"recovery is not a linear line, its ups and downs and stops and starts, sometimes episodic and needs the holistic approach applied. We are working with people, and all their rich diversity and challenges"* (Mental Health Victoria, 2021b, p. 18).

Lived Experience Workshop participants provided examples where support workers had no knowledge of mental health and had to be 'educated' by the participant. *"Self-responsibility and knowledge of disabilities – it's not up to the client to teach and educate you about their disability. They should have an opportunity to if they wish, but it's a lot of emotional labour, it would be great if workers did their own homework, and they should get that information from people with lived experiences"* (Mental Health Victoria, 2021a, p. 9).

The Lived Experience Workshop participants expressed a need for support workers to have skills in emotional coregulation and de-escalation. One workshop participant said that: *"The other role I look for is a mentor as I am trying not to rely on my parents, but also find it hard to regulate my own emotions and struggle with functioning, also a de-escalating or calming role"* (Mental Health Victoria, 2021a, p. 36). As a Worker Workshop participant describes *"meeting people where they are at on that day, if they are having a good day meet them there, or a bad day meet them there"* (Mental Health Victoria, 2021b, p. 18). Improved understanding of symptoms and medication effects was considered essential. This includes challenges such as, changes in capacity, difficulty concentrating, fatigue, physical changes. One Lived Experience workshop participant said: *"Because you did this yesterday, people assume you'll be able to do it today. Well, it doesn't work like that"* (Mental Health Victoria, 2021a, p. 38).

Responding to distress is a key skill for the psychosocial disability context. As a Worker attendee illustrates *"it varies, no two days are the same, we are supporting people who quite often have complex situations or distressing situations"* (Mental Health Victoria, 2021b, p. 18). Lived Experience Workshop participants reported examples where support workers had responded to distress inappropriately (Mental Health Victoria, 2021a). For example, *"we want to avoid mental health system and hospitals, but quite often directed there 'sedate and stabilise' is sadly a common suggestion"* (Mental Health Victoria, 2021a, p. 37).

Availability of a Lived Experience Worker

As reported in the Phase 1 report, Lived Experience Workshop participants discussed the availability of support workers with lived experience. As a Lived Experience participant describes *"I want to have a lived experience worker, who is also matched with my needs"* (Mental Health Victoria, 2021a, p. 24). Lived Experience Workshop participants not only discussed access to workers in lived experience roles but also the need to have choice of workers. Notably, this was reflected in the Phase 2 report, where Provider Workshop participants discussed the current efforts to recruit lived experience workers in peer work and recovery coach roles (Mental Health Victoria, 2021b). Additionally, the Provider Workshop participants raised recruiting staff from Aboriginal and Torres Strait Islander communities, Culturally and Linguistically Diverse backgrounds and LGBTIQ+ identity groups.

Barriers to Communication, Collaboration and Coordination

Communication, collaboration, and coordination at different levels was raised numerous times in the Phase 1 report. This includes the interpersonal, between worker and NDIS participant, within the provider organisation and to external organisations. As a Lived Experience Workshop participant suggests *"…have*

a focus from providers on communication and sharing information – be clear with workers about what the organisation's expectations are. Clarity around GOOD communication. This has many positives if done well." (Mental Health Victoria, 2021a, p. 29).The impact of poor communication was also mentioned. For example, *"good communication and consideration, today I had a support worker I had never met show up for a shift I had no idea was scheduled"* (Lived Experience Workshop participant as quoted in (Mental Health Victoria, 2021a, p. 13).

The importance of collaboration with the NDIS participant's family and carers was also highlighted. As Mental Health Victoria describes *"there is a great opportunity for the worker and provider to build effective relationships and communication with the family members/ carers"* (2021a, p. 27). However, as they further state *"carers often reported that they felt they were needing to orient the workers to their roles"* (Mental Health Victoria, 2021a, p. 40).

As a participant of the Worker Workshops states *"it's a collaborative approach we all have a piece of the puzzle, we all are skilled in our own areas, and we all need to work together to help make a robust recovery for the people we are working with"* (Mental Health Victoria, 2021b, p. 18). The benefits of communication, collaboration and communication was acknowledged by workers, providers and NDIS participants and carers alike. As a provider reflected in the Phase 2 report *"when we collaborate with other organisations, we found this was good for development but also we're able to find the right fit for clients"* (Mental Health Victoria, 2021b, p. 14).

Collaboration with Providers

The Phase 1 and 2 reports highlighted challenges in communication and collaboration. This included collaboration internally within the provider organisation, collaboration with other NDIS providers, external organisations and with the NDIA. A Lived Experience Workshop participant stated that *"[they] need something where they can have team meetings to handover on participant. I want my support worker to have time to debrief, even by Zoom, once a fortnight or once a month to be able to say – has anyone followed up on this? Or this?"* (Mental Health Victoria, 2021a, p. 28). This better collaboration also extends to families and carers, *"workshop members recognised the importance of the multi-disciplinary approaches and carers spoke of the importance of being included in these teams"* (Mental Health Victoria, 2021a, p. 28).

NDIS workers described this as a large part of their roles *"supporting people to prepare for plan reviews, assessments and report writing for plan reviews, helping client to work more effectively with other supports, working with client's other supports on client's behalf"* (Mental Health Victoria, 2021b, p. 18).

Workshop participants discussed a need for increased collaboration and communication with the NDIA and the provider. For example, Lived Experience Workshop Participants experienced issues of duplication or missing information from the NDIA to the provider, resulting in the burden of additional and unnecessary forms and paperwork (Mental Health Victoria, 2021a). Furthermore, Provider Workshop attendees describe challenges in accessing information from the NDIA. They suggest *"co-location of services in the same building would be really beneficial. The official contacts are often not who you really need – it's often someone you know where you get somewhere. NDIA is the worst. Trying to find someone to respond to you is a nightmare, it's only by knowing someone that you can get in"* (Mental Health Victoria, 2021b, p. 21).

Communication with NDIS Participants, their Families and Carers

The Lived Experience Codesign Workshop Report highlighted the perspectives of NDIS participants and their carers regarding communication. One participant said: *"at the moment there are heaps of issues with poor communication in services and that leaves participants having to chase up things multiple times and often not knowing till the last minute what's happening"* (Mental Health Victoria, 2021a, p. 29). Other instances of communication breakdown arise where workers do not attend their shifts. A Lived Experience Workshop participant reported: "*Workers not turning up – even though the participant has called, the worker hasn't informed the provider, leaving the participant with no one. This is a big issue, workers not being reliable. Provider needs to check in on workers, so they can find someone else if a worker isn't available*" (Mental Health Victoria, 2021a, p. 22).

Finally, the communication needs the of Lived Experience Workshop Participants was discussed. As a participant describes, expectations and boundaries about communication, especially for contact out of hours, need to be discussed and agreed upon (Mental Health Victoria, 2021a). Notably, the type of communication mechanism should be outlined as well to avoid intrusion on the Worker, and to convey respect: *"[I] need the ability to contact a person outside of the shift hours because at the end of the shift that's it – to contact them to organise things to do on the shift, etc. I haven't had people in the past with phone contacts. I feel like I am crossing the boundary by texting them. Different providers have different rules. Email system or instant chat – forget about that. But an email vs a text message. A mechanism to email providers or workers about upcoming shifts. Texting a worker feels like it is crossing a boundary. Need to make sure it is respectful on both sides"* (Mental Health Victoria, 2021a, p. 23).

Connection to Informal Supports

NDIS participants and their cares who participated in Lived Experience Codesign Workshops reported that the connection between support workers and informal supports was crucial. In particular, the need for support workers to learn, acknowledge and navigate the complex relationships and supports of the NDIS participant (Mental Health Victoria, 2021a). The workshop found that support workers need high level interpersonal skills and empathy to ensure that these relationships are supported and respected, but also to navigate tensions or conflicts. Also, support workers should not make assumptions about these relationships and to be sensitive to the preferences of the NDIS participant, particularly about birthdays and holidays (Mental Health Victoria, 2021a).

Supporting the Carer Role

The Lived Experience Codesign Workshop Report drew attention to the important and sensitive role of working alongside carers. A workshop participant said that *"I have experienced patronising and patriarchal behaviour…not listening to me as an advocate, put down by staff, unsupportive. I'm the one that's there all the time. Be respectful of that. I'm not trying to control [the participant], I'm there to support [the participant] to articulate their needs and exercise their choice and control"* (Mental Health Victoria, 2021a, p. 27).

The impact on carers was discussed by Lived Experience Workshop participants including gaps in plan funding, the complexity of the NDIS, role confusion, poor communication and changed processes. As one Lived Experience Workshop participant describes *"there's always so much. An app would be great. Need something legislated to help carers with being able to navigate everything"* (Mental Health Victoria, 2021a, p. 40).

Notably, Mental Health Victoria reported that carers from CALD backgrounds in particular had reported an increase in their caring role (Mental Health Victoria, 2021a).

Barriers to Social Inclusion and Social Determinants

Elements from the social inclusion and social determinants domain were also raised by Lived Experience Workshop participants. As a participant affirmed *"if workers don't know about human rights and social determinants then they shouldn't work in this field"* (Mental Health Victoria, 2021a, p. 38). Issues that impact social inclusion and the perpetuation of stigma such as the use of language were also raised. As a Lived Experience Workshop participant articulates *"I have mental health concerns and experiences, but I am not those. I am not 'schizophrenia', I am a human. Using labels is disparaging. The language is becoming inhuman and impersonal"* (Mental Health Victoria, 2021a, p. 34).

The significance of advocacy to address social determinants and promote social inclusion was also discussed by Lived Experience Workshop participants, *"advocacy – recognise the vulnerability of the person in the face of powerful institutions, housing, Centrelink etc. Embody anti-oppressive practice. Strong in the face of injustice"* (Mental Health Victoria, 2021a, p. 10).

Cultural Safety

The needs of the Key Priority Groups for this project were discussed in both the Phase 1 and 2 reports with a leading barrier being cultural safety. As Mental Health Victoria state, describing the feedback from

Lived Experience Workshop attendees, *"a lot of people hold different identities, it's important for NDIS agencies to acknowledge these. if this is not done well then people will feel marginalised and this puts recovery-oriented support at risk"* (2021a, p. 24). Additionally, the need for workers to reflect on their own cross-cultural beliefs about mental illness was discussed by Lived Experience Workshop participants. *"Different cultures understand mental illness in different ways and this can be an issue with workers from different cultural backgrounds"* (Mental Health Victoria, 2021a, p. 24).

The impact of the NDIS on cultural safety was also reflected in unforeseen ways. For example, Provider Workshop participants reported that the current service model impacted the attendance of their staff at culturally significant events, *"workers are less able to support Participants who require support to attend groups and culturally significant events. e.g., LGBTIQ individuals who want to participate in a pride event"* (Mental Health Victoria, 2021b, p. 12).

The Phase 2 report made specific recommendations for cultural safety for Aboriginal and Torres Strait Islander participants. These included: having Aboriginal health practitioners on staff, acknowledging displacement and intergenerational trauma, and knowing links back to country (Mental Health Victoria, 2021b).

Human Rights

As Mental Health Victoria conveys in the Phase 1 report, NDIS participants and carers described incidents of breaches to their rights in the past and present (Mental Health Victoria, 2021a). Subsequently, Lived Experience Workshop participants advocated for support workers to be educated in human rights approaches, and for them to advocate on behalf of NDIS participants where rights have been breached (Mental Health Victoria, 2021a).

Access to Advocacy and Complaints Process

Challenges for advocacy was emphasised in both the Phase 1 and 2 reports. Advocacy included acting as social change agents, community engagement, direct advocacy activities, and policy engagement. Provider Workshop participants discussed the barriers for organisations to engage in advocacy activities and to act as social change agents (Mental Health Victoria, 2021b). These barriers included a reduced capacity as a result of the funding structures of NDIS. For example, in a fee-for-service model, as opposed to a block funding model, community engagement, attendance at community and sector events, and activism are no longer funded (Mental Health Victoria, 2021b, p. 12).

Lived Experience Workshop participants reported that the complaints process was not consistent across providers and there are insufficient organisational policies to support a robust feedback process (Mental Health Victoria, 2021a). As they describe *"those of us taking part in this workshop are reasonably educated around NDIS and able to advocate for our needs. What SHOULD be the minimum often is not and people with disability don't always know what their rights are, what rights are being violated or how to address it if they are violated which provides a perfect storm for providers to be able to NOT address the minimum. Where is the open disclosure process? So many NDIS providers don't even have a complaints policy for participants to put forward their complaints/issues in a positive way and have them addressed"* (Mental Health Victoria, 2021a, p. 21).

Dignity of Risk and Supporting Positive Risk Taking

The feedback from the Phase 1 report acknowledged that *"duty of care vs dignity of risk"* is a complex issue which will require support from the NDIS and providers in order to support workers to navigate this in a constructive, client centred and safe way (Mental Health Victoria, 2021a, p. 30). Lived Experience Workshop participants advocated for support workers to engage in an empowering approach that provides choice, self-determination and dignity of risk. As they describe *"working together with the participant as a team and being 'willing to give it a go' was one example of how participants felt workers could be a 'helper' not a 'hinderer', building skills and confidence"* (Mental Health Victoria, 2021a, p. 32).

Organisational Barriers to Recovery-Oriented Practice

Interlinking with ROPDS workforce capabilities, which describe the knowledge, values and skills required for NDIS workers, the organisational capabilities describe what is needed at an organisational level to support ROPDS. The ROPDS organisational capabilities were discussed in The Future Horizon report and arranged into the following domains, as depicted in Figure 6 below:

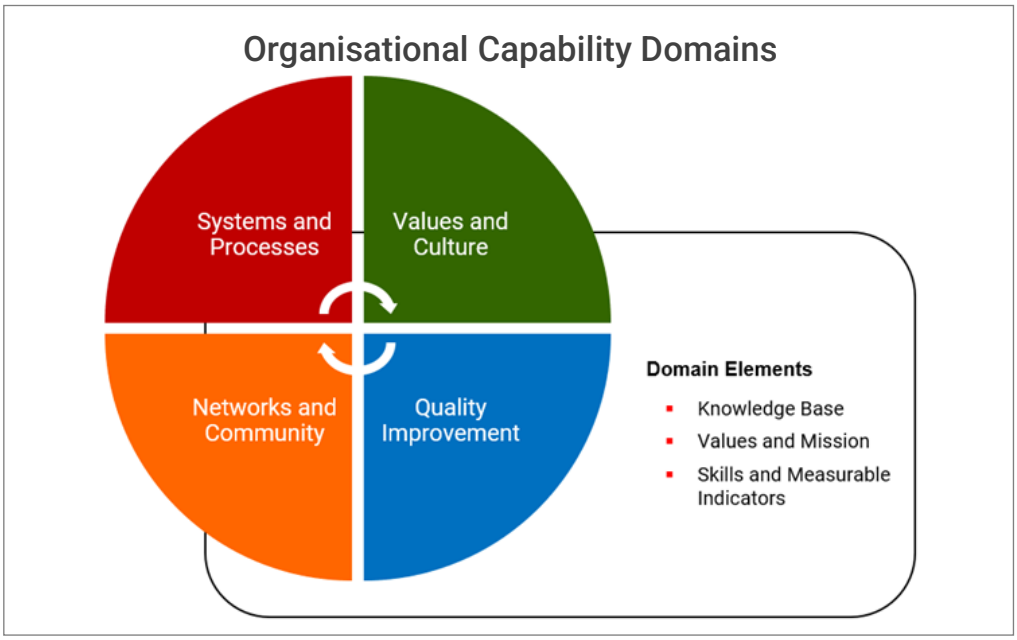

FIGURE 6: ORGANISATIONAL CAPABILITY DOMAINS.
From The Future Horizon by Brophy et al. (2021b, p. 49).

The Phase 1 and 2 reports both describe challenges and barriers to ROPDS that arise through organisational and systemic factors that impact the quality and safety of recovery-oriented service delivery. However, in the Phase 2 report Provider Participants reported on specific barriers to ROPDS service delivery. As shown in Figure 7 below, the top five reported barriers to ROPDS are training and professional development, time, fragmented funding, billable hours, and staff supply and burnout.

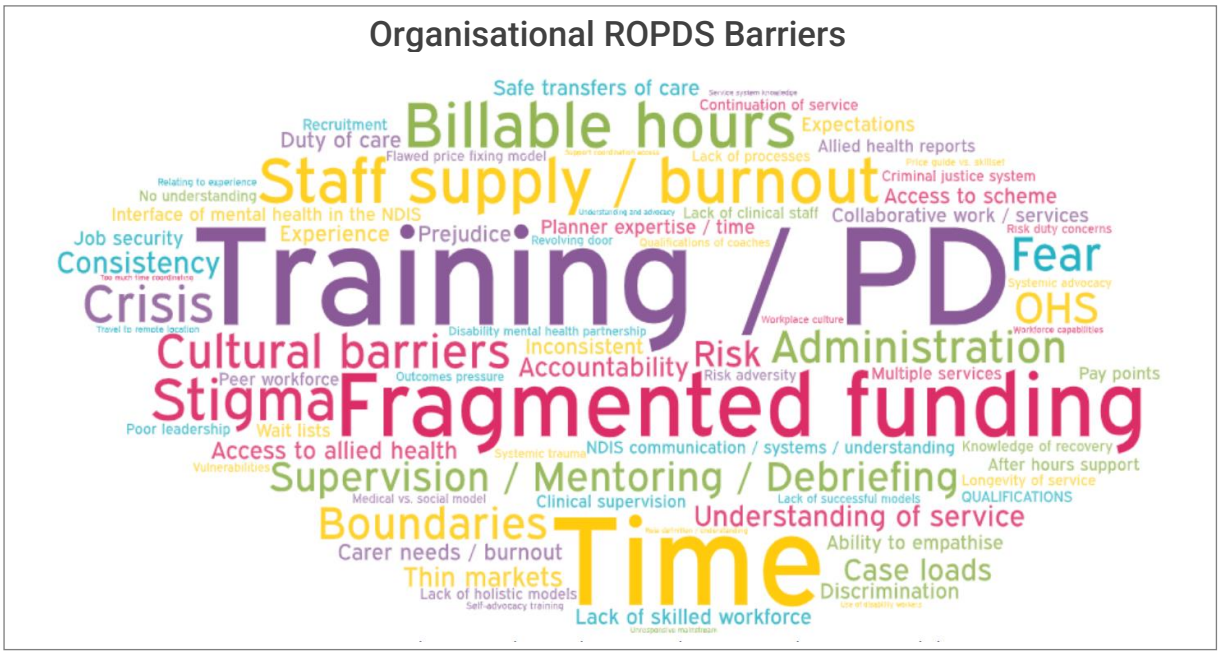

FIGURE 7: BARRIERS TO RECOVERY-ORIENTED NDIS PSYCHOSOCIAL SERVICE DELIVERY
As described by NDIS psychosocial service providers in the Phase 2 report (Mental Health Victoria, 2021b, p. 11).

Quality and Safety

The quality and safety of service provision were broadly discussed in both the Phase 1 and 2 reports. As a Lived Experience workshop participant describes, *"there is a big concern for me ..... Going to an org such as that, where you don't feel your information is protected enough, and that person who is selected may not be safe. There are not enough checks and balances for people with MH [Mental health]. How do you ensure the consistency of standards?"* (Mental Health Victoria, 2021a, p. 30).

In the Phase 1 report, NDIS participants and carers drew attention to the impact of conflicting interests that must be managed ethically by providers. For example, *"[Lived Experience] workshop attendees identified examples of conflicts of interest that they found to be ethically questionable, when professionals made referrals to family members and examples where providers are seen to support their own business model, rather than led by the individual client needs"* (Mental Health Victoria, 2021a, p. 29).

The free-market model of the NDIS may reduce the protections and standards for NDIS participants that were previously upheld and monitored in state-based and NGO systems. As another Lived Experience Workshop participant shared: *"What I've found is that the mental health workers that have all left the NGO space and opened independent businesses to support NDIS participants. They are definitely getting a higher hourly rate, and none of the policies and procedures that would have traditionally protected participants accessing services are in place"* (Mental Health Victoria, 2021a, p. 30). This includes challenges for new providers and sole practitioners. Workers consistently reported a disproportionate cost burden where training is not funded to ensure that they were utilising best practice (Mental Health Victoria, 2021b). As a Worker describes, *"we should be equipped with the tools to implement these therapies on the ground but I do a lot of self-study, I will sign up for this and pay for it myself, but it would be great for everyone to have an upskill on these things"* (Mental Health Victoria, 2021b).

As providers reflected in the Phase 2 report, monitoring the quality of services and ensuring that workers are meeting capabilities is challenging in a diverse and transient workforce (Mental Health Victoria, 2021b). Notably, the NDIS workforce is largely working in-home and community-based, with supervision and training largely unfunded in the current NDIS model (Mental Health Victoria, 2021b). As a Worker Workshop participant comments, this has been of particular concern during the pandemic *"layer of lockdowns and non-office roles, has added complexities to a role that already might be quite isolated from colleagues and supervisors"* (Mental Health Victoria, 2021b).

Professional Behaviour

Concerningly, the professionalism of support workers was reported to be a strong theme in the Lived Experience Codesign Workshop Report (Mental Health Victoria, 2021a). Key issues reported by Lived Experience Workshop participants included unprofessional behaviours, privacy and confidentiality breaches, punctuality, time-theft, poor boundaries, duty of care, and worker disengagement.

For example, Lived Experience Workshop participants reported incidents of privacy and confidentiality breaches, as they describe *"...I get sick of workers talking about other clients they work with – it just means they could also be talking about me. They can talk about experiences, don't need to go into so much description"* (Mental Health Victoria, 2021a, p. 33). Other incidents included workers bringing their children with them to the participant's home, unbeknownst to the NDIS participant and carers, and workers using their phones or engaging in personal activities inappropriately (Mental Health Victoria, 2021b).

Use of self and disclosure was also discussed, with the importance of workers being able to discern when and what to disclose to the participant described as a valued skill by Lived Experience Workshop participants (Mental Health Victoria, 2021a).

Role Definition and Clarity

Providers and Workers in the Phase 2 report discussed challenges arising through a lack of clarity and definition of psychosocial worker roles (Mental Health Victoria, 2021b). Notably, the recovery coach role was reported to have different expectations depending on the provider. As a Worker Workshop participant states *"it sounds like Recovery Coaches are doing a specialised support coordination role, not a*

Recovery Coach role" (Mental Health Victoria, 2021b, p. 19). Notably, Provider participants reported challenges in NDIS plans where there was a lack of flexibility for support hours and the need to negotiate how support hours are to be utilised, resulting in confusion for NDIS participants and providers (Mental Health Victoria, 2021b).

Worker Training

Recovery-oriented practice training and development was reported to be the leading barrier for ROPDS by Provider Workshop participants (Mental Health Victoria, 2021b). As a Worker Workshop attendee reports *"you are supposed to be using evidence based to be delivering service but it's not really happening, and a lot of people aren't aware of what those programs are and are not trained in. If training is not paid it won't happen and I don't think the NDIS has any way of keeping track of that anyway"* (Mental Health Victoria, 2021b, p. 19).

Notably, training was discussed extensively in both the Phase 1 and 2 reports particularly in trauma informed care, social determinants and human rights, foundational mental health skills and recovery-oriented practice (Mental Health Victoria, 2021a, 2021b).

However as a Worker Workshop attendee reports, the training and development is at the cost and behest of the workers *"we should be equipped with the tools to implement these therapies on the ground but I do a lot of self-study, I will sign up for this and pay for it myself, but it would be great for everyone to have an upskill on these things"* (Mental Health Victoria, 2021b, p. 19).

In terms of credentialling and mandatory training, Lived Experience Workshop participants had differing views about qualifications for the NDIS workforce. Lived Experience Workshop participants agreed that all psychosocial disability support workers needed a base level understanding of recovery-oriented practice, however some discussed the need for a higher-level education than the current Certificate III and IV qualifications for many support workers. Whereas other Lived Experience Workshop participants expressed concern that a mandatory minimum qualification impacts the availably of workers for certain tasks where a higher level of qualification is not needed, or workers who are currently studying and upskilling (Mental Health Victoria, 2021a).

Lived Experience Workshop participants also discussed the need for training for lived experience and peer workers. As Mental Health Victoria (2021b) describe, issues with appropriate use of self and communication by peer workers was discussed by Lived Experience Workshop participants. For example: *"lived experience worker – sometimes it's good and sometimes it's not*" (Mental Health Victoria, 2021a, p. 41).

Supervision and Support

Access to professional supervision and supports is another key issue for the NDIS psychosocial disability workforce (Mental Health Victoria, 2021a, 2021b). In the Phase 2 report NDIS workers state *"[there is] very little time for reflection or thinking, NDIS pressure with dollar and time. Allowance for self-care, vicarious trauma, having space, checking in with team leader, etc. This is a really important part of making your days productive and successful and making sure you have good outcomes for your participant and yourself."* (Mental Health Victoria, 2021b, p. 19).

Discussion of Findings

The aim of this section is to explore what the Phase 1 and 2 reports add to the findings from the Current Landscape and Future Horizon reports and to identify the leading barriers to recovery-oriented psychosocial disability support (ROPDS) in the current NDIS environment.

Using the ROPDS workforce capability framework from the Future Horizon report, the barriers to recovery-oriented practice in each domain were described. The ROPDS workforce capability domains include person-centred, supporting personal recovery, collaboration, communication and coordination, and social determinants and social inclusion. Barriers to ROPDS organisational capabilities were also considered, including systems and processes, values and culture, networks and community, and quality improvement. These findings have been further interpreted using the literature from the Current Landscape report. The Current Landscape literature review described the following practice perspectives:

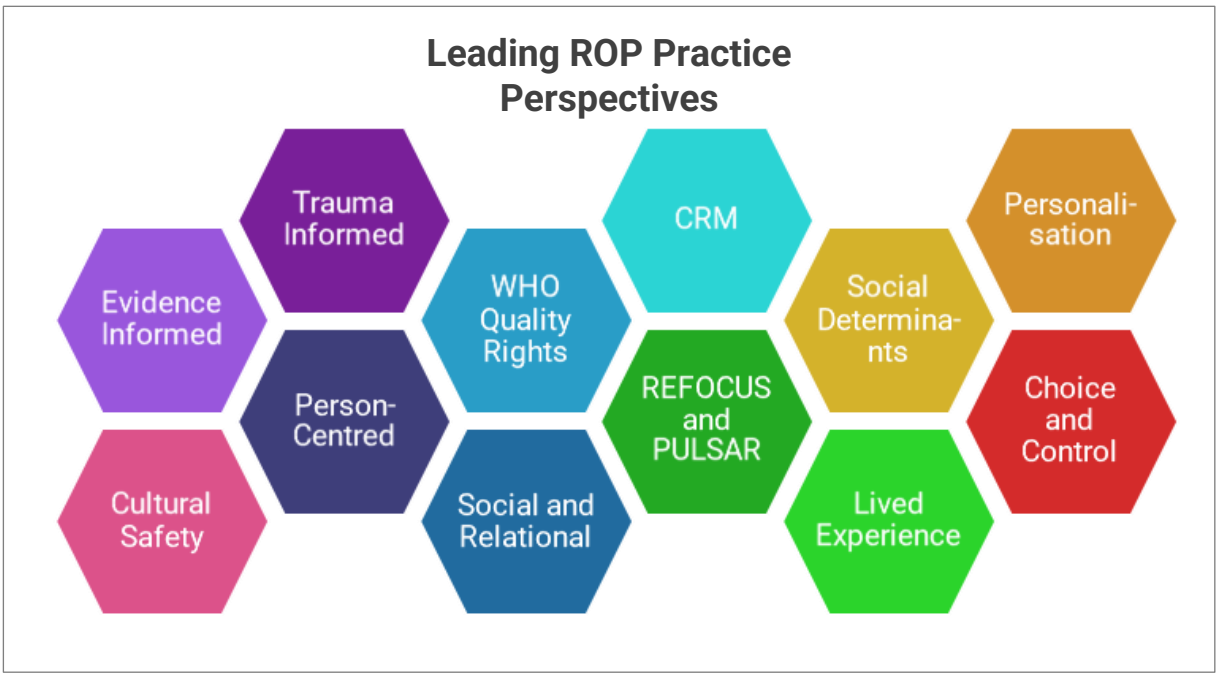

FIGURE 8: LEADING RECOVERY-ORIENTED PRACTICE PERSPECTIVES.
Adapted from the Current Landscape (Brophy et al., 2021a).

Barriers to ROPDS

The barriers to ROPDS emerge in several key areas of impact in service provision in the NDIS context. These can be described through the following themes: worker-participant relationship, choice and control, human rights, collaboration, evaluation, accountability and quality assurance, and ROP training.

Worker-Participant Relationship

At the epicentre of recovery-oriented practice is the partnership or alliance between the worker and the consumer/participant (Chester et al., 2016; Klevan et al., 2021; Winsper et al., 2020). As Topor et al. (2011, p. 91) express, the work of recovery takes place in the interpersonal and social context. The barriers to person-centred care each represent challenges for the worker participant relationship.

A worker's interpersonal skills and rapport form the basis of the worker-participant relationship. As Chester et al. (2016) explore, recovery-supportive relationships are collaborative; valuing consumers' experiential knowledge, and cyclical, where the practice of listening and understanding the consumer promotes the practitioners' ability to support recovery. In their systematic review, Winsper et al. (2020) found that a strong working alliance was associated with improved quality of life, confidence, hope, connectedness, self-determination, wellbeing, empowerment and other recovery outcomes.

Topor et al. (2018) promote the use of helpful micro-affirmations as actions that assist the consumer in improving a sense of self and fostering recovery. These micro-affirmations or 'small-things' "are usually things happening unnoticed in ordinary life," such as words (e.g. use of self, small talk), gestures (e.g. a smile, eye contact), and actions (e.g. offering coffee, just being there) (Topor et al., 2018, p. 1214). These interpersonal skills include good communication and listening skills, "the recovery approach re-emphasizes the importance of these skills and additionally requires a shift in the power dynamics towards more balanced and equal relationships" (World Health Organization, 2019c, p. 41).

This balanced and equal relationship between worker and participant is challenged where there are instances of low expectations and stigma. In their research, Shera and Ramon (2013, p. 19) found that "stigma, both societal and professional, is one of the most enduring barriers to moving to a more humane, recovery-oriented system of care for persons who are experiencing a mental illness." Notably, this finding highlights the role and importance of recovery values, training and supervision. As stated by Meadows et al. (2016) "values underpin all behaviours by mental health service providers" (p. 8). Education in recovery and its values, and supervision to support the training, provides the necessary foundations for workers to engage in ROP (Meadows et al., 2016).

Workforce retention and recruitment have a significant impact on the worker-participant relationship. As discussed in both the Phase 1 and 2 reports, the relationship cannot form without enough time, and it is challenging for participants when their worker leaves. Erondu and McGraw (2021) explored barriers to implementation of recovery-oriented practice in the community health setting in the UK. They found that workload and capacity of providers had a significant impact on recovery-oriented practice. This was further impacted by high turnover, and the expense of training and supervision (Erondu & McGraw, 2021).

Choice and Control

The Phase 1 and 2 reports described multiple barriers to the choice and control of NDIS participants and their carers. As previously reported in The Current Landscape and Future Horizon, promoting choice and control is a leading enabler of recovery. It is also a key component of the objectives in the *National Disability Insurance Scheme Act 2013* (Cth). Despite the individualised funding model of the NDIS, Wilson et al found that choice and control faced multiple challenges including thin markets, a lack of information about available services, and limits to funding for certain supports (Wilson et al., 2021). These findings echoed some of the challenges experienced by Lived Experience Workshop participants, including having a choice of worker, access to lived experience/peer workers, flexibility of supports, and complex systems navigation (Mental Health Victoria, 2021a). Notably, the broader NDIS market and workforce that impact choice of worker, flexibility, and access to lived experience workers, include skilled workforce shortages, retention, and recruitment. In their scoping review of NDIS and psychosocial disability literature, Hamilton et al. (2020) found that the service delivery model of the NDIS creates challenges "where it is not flexible enough to respond to the fluctuating support needs and uniquely episodic nature of PSD [psychosocial disability]" (Hamilton et al., 2020, p. 1169). Research by Doroud et al. (2021) highlights the phases that people experience in their recovery journeys, as they term "a journey of living well". This journey was described as 1) living a life on hold; 2) choosing to recover; and 3) learning and navigating strategies (Doroud et al., 2021). Notably, the findings of this research highlighted the importance of engaging in meaningful activities and supporting choice and control (Doroud et al., 2021).

In their systematic review of recovery literature, Winsper et al (2020) found that increasing choice and opportunities was one of the four recovery-oriented mechanisms of action that promote recovery outcomes. Interventions that increase choice and control were associated with increased empowerment, self-determination, social inclusion, citizenship and wellbeing (Winsper et al., 2020). The review highlighted the importance of lived experience/peer programs and work roles to improve recovery outcomes. In the review, each of the mechanisms of action of recovery (providing information and teaching skills, promoting a working alliance, role modelling individual recovery, increasing choice and opportunities) featured lived experience interventions (Winsper et al., 2020). Lived experience based interventions included: peer specialists, recovery colleges, peer-led club-houses, mental health ambassadors and community development projects (Winsper et al., 2020).

Human Rights and Social Inclusion

Several of the findings have implications for the rights of participants, including cultural safety, advocacy and complaints, and dignity of risk. As the WHO (2019c, p. xi) explore, a rights focus is a key enabler for recovery-oriented practice to ensure the realisation of "…key rights such as equality, non-discrimination, legal capacity, informed consent and community inclusion (all enshrined in the Convention on the Rights of Persons with Disabilities)." Notably, Provider Workshop participants described billable hour restrictions in NDIS plans as a key barrier to community engagement and activism (Mental Health Victoria, 2021a).

Advocacy was raised in several areas in the findings, notably supporting self-advocacy by NDIS participants and carers, and workers and providers acting as social agents for change. It is important to reflect on the origins of recovery, which emerged from the mental health consumer/survivor movement advocating for change, to end stigma and discrimination, to value lived experience perspectives and foster lived experience practitioners (Deegan, 1996; Frese & Walker Davis, 1997). The work of recovery as a realisation of advocacy activities for and by people with mental health conditions and psychosocial disability is ongoing. As such, the fourth objective of the WHO QualityRights Initiative for mental health services is to "support the development of a civil society movement to conduct advocacy and influence policy-making" (World Health Organisation, 2019). As they describe, ROP not only involves work with the consumer or participant but also as an agent for change within the organisation and in "broader forms of action such as advocacy and awareness-raising" (World Health Organization, 2019c, p. 27). Notably, a key task for acting as a social change agent is addressing the social determinants of mental health.

Reflecting the findings of the Phase 1 and 2 reports, access to culturally appropriate care was reported as a barrier to recovery-oriented practice in the community mental health setting in the UK (Erondu & McGraw, 2021). In a Western Australian study with mental health practitioners, McGough et al. (2018) explored the process of becoming a culturally safe practitioner when working with Indigenous Australians. The research found that becoming culturally competent was a social psychological process where practitioners moved from being unprepared (disrupting self-awareness and fluctuating emotions) to seeking and navigating solutions (neutralising difference, taking next step, seeking new solutions and becoming culturally safe) (McGough et al., 2018).

A possible gap in the NDIS service model that emerges from the Phase 1 and 2 reports, is the promotion of social inclusion and participation for NDIS participants and carers. Notably, Provider Workshop Participants describe access and participation to community events and engagement as not possible due to funding and budgets (Mental Health Victoria, 2021b). Rowe and Davidson (2016) advocate for a shift in service delivery models to move away from the individualistic focus to a social inclusion model through a process that they term 'recovering citizenship.' As they describe, 'recovering citizenship' is a concept and metaphor for the recovery process that takes place in the context of the community and its broader structures or 'citizenship framework' (Rowe & Davidson, 2016). Citizenship in society is associated with the strength of connection and enjoyment of the "rights, responsibilities, roles, resources and relationships that a democratic society makes available to its members" through public and social institutions (Rowe & Davidson, 2016, p. 17). Recovering citizenship can be achieved through individual efforts and supports or through societal and government responses and policies (Rowe & Davidson, 2016). As they discuss, the emphasis of recovering citizenship is on addressing the social determinants (Rowe & Davidson, 2016).

Collaboration

The importance of collaboration to recovery is described by multiple sources in recovery literature (Shera & Ramon, 2013; Thomas et al., 2018; World Health Organization, 2021). In their scoping review, Hamilton et al. (2020) reported on studies with people with psychosocial disability or severe and persistent mental illness and the NDIS. Themes were then analysed using a strengths, weaknesses, opportunities and threats (SWOT) matrix. Hamilton et al. (2020) reported that several studies described a division between health and disability services that impacts disproportionately on people with mental health conditions and can result in some needs not being met. The SWOT suggested that the NDIS represents opportunities in system integration through inter-government and interagency networks which can improve service access and create referral pathways between services (Hamilton et al., 2020).

Systems integration is a key recommendation from the WHO Guidance for Community Mental Health Services. The WHO (2021) endorses the integration of health and social services (housing, employment, education, social protection and other supports) as fundamental to recovery-oriented services. Further this integration supports community inclusion and promoting the human rights of people with psychosocial disability (World Health Organization, 2021).

Collaboration by providers and workers impacts not only NDIS participants but also their families and carers. Maybery et al. (2021) found seven core ways in which families and carers can be engaged by mental health services, including identification and acknowledgement, engaging and communicating, involvement in planning and collaboration, assessing needs, ongoing supports, psychoeducation and referral. In 2016, Mind Australia and Helping Minds developed the *Practical guide for working with carers of people with a mental illness*. The guide was developed using the Triangle of Care Model, which describes the recovery process through the partnership and relationship of consumer, carer and provider (Mind Australia & Helping Minds, 2016). Fox et al. (2015) interviewed eleven carers following training in recovery and they found that the three-cornered partnership between carer, professional, and service user is fundamental to recovery and that boundaries and confidentiality must be negotiated in these partnerships. Notably, training in recovery for carers was associated with increased hope and optimism, and carers felt more empowered to challenge stigma from professionals and had increased confidence in their own expertise (Fox et al., 2015).

Evaluation, Accountability, and Quality assurance

Given the reported challenges in ensuring the quality and safety of NDIS services, it is important to explore this in relation to its impact on recovery-oriented practice. As described in the enablers of recovery-oriented practice from the Current Landscape, “recovery-oriented practice starts at the top” (Brophy et al., 2021a, p. 35). The commitment of organisations and providers to ROP and recovery values is essential to the success of ROP (Bauer et al., 2019; Gee et al., 2017; Lorien et al., 2020; Meadows et al., 2019; Shera & Ramon, 2013; World Health Organization, 2021).

Bauer et al. (2019) conducted research exploring the organisational characteristics and environments of ROP. They interviewed twelve senior staff from five mental health organisations that engage in recovery-oriented practice and have significant experience with user-led and focused practice initiatives (Bauer et al., 2019). Baur et al. (2019) found that ROP was enabled by the following organisational characteristics: a sense of community, organisational empowerment, shared leadership, and decision-making. The research also raised the importance of offering social, educational and creative activities to promote recovery (Bauer et al., 2019).

Evaluation, including a rigorous and transparent complaints system, is an important feature of ROP. These activities can assist to determine satisfaction with services, recovery outcomes, and allow for the collection of lived experience perspectives. As Scholz et al. (2017) describe, promoting consumer involvement in mental health services can be achieved through several means, including soliciting consumer feedback through surveys and complaints processes and engaging consumer leaders in leadership and hiring roles. Feedback from NDIS participants is also associated with empowering people to voice their preferences, choices and needs, promoting their rights, and enabling choice and control. The World Health Organization (2021) describes the feedback and complaints process as essential to non-coercive practices, respecting legal capacity, participation in services, promoting a rights focus, and person-centred approaches. From their scoping review, Hamilton et al. (2020) make clear recommendations to the NDIA regarding the need for further evaluation and research measures:

> Finally, the NDIA needs to continue to seek out evidence from, and be responsive to, the needs and values of people with psychosocial disability and those who support them. While the individualised nature of each person’s needs and thus their NDIS plans makes research and evaluation challenging, it is essential that we understand whether NDIS plans ultimately have an impact on the lives of programme participants and to ensure this very large investment is delivering value for money. (Hamilton et al., 2020, p. 1170).

ROP Training

Worker training is another crucial area for providers and organisations. ROP training improves recovery outcomes and can increase the quality and safety of providers and organisations. As discussed in the Current Landscape and Future Horizon reports, multiple reviews have explored the efficacy, implementation and outcomes of ROP training in various mental health settings (Eiroa-Orosa & García-Mieres, 2019; Gee et al., 2017; Jackson-Blott et al., 2019; Lorien et al., 2020; Shera & Ramon, 2013). In table two, the findings and implications of the literature reviews are outlined:

TABLE 2: ROP TRAINING AND IMPLEMENTATION LITERATURE REVIEWS

Review	Outcome	Findings	Implications
A systematic review and meta-analysis of recovery educational interventions for mental health professionals (Eiroa-Orosa & Garcia-Mieres, 2019).	Recovery Training	Recovery training programs have a statistically significant impact on beliefs and attitudes but not on practices.	Qualitative evidence suggests that organisational obstacles can impair training efficacy.
Recovery-oriented training programmes for mental health professionals: A narrative literature review (Jackson-Blott et al., 2019).	Recovery Training	Recovery training has the potential to improve staff knowledge, attitudes, and competencies in ROP. Recovery training may have limited influence on clinical practice. The effectiveness of staff training was not conclusive.	Recommends that training is provided as part of wider organisational change to ensure changes in staff ROP practice.
Rapid realist review of the evidence: achieving lasting change when mental health rehabilitation staff undertake recovery-oriented training (Gee et al., 2017).	ROP Implement-ation	Six processes enable lasting change in ROP implementation: collaborative action planning, regular collaborative meetings, appointing a change agent, explicit management endorsement and prioritisation and modifying organisational structures.	Barriers to change arise from organisational climate and 'change fatigue.' Organisational analysis to identify barriers prior to implementation may ensure successful cultural change.
Implementation of recovery-oriented practice in hospital-based mental health services: A systematic review (Lorien et al., 2020).	ROP Implement-ation	ROP implementation is feasible, albeit challenging. Enablers include approaches that are multimodal, applied over several years and have organisational support.	Implementation barriers included change resistance away from the biomedical model and staff attitudes toward recovery. Consumer involvement in implementation was associated with success.
Challenges in the implementation of recovery-oriented mental health policies and services (Shera & Ramon, 2013).	ROP Policy Implement-ation	Challenges for ROP sector change included clarity of recovery definition, stigma, resourcing, program implementation, differing paradigms between consumers and professionals and political will.	Implications for implementation at an organisational level, Resources, culture, capacity, inclusive process of organisational change.

The findings of the reviews suggest that the efficacy of ROP training and implementation requires coinciding organisational systems and supports (Eiroa-Orosa & García-Mieres, 2019; Gee et al., 2017; Jackson-Blott et al., 2019). As Jackson-Blott et al. (2019, p. 113) state, "whilst recovery training may have some utility in improving recovery-oriented staff outcomes, training needs to be provided as part of wider organisational change to ensure this translates into clinical practice."

This was reflected in Australian research, exploring the efficacy of collaborative recovery training with community mental health practitioners (Uppal et al., 2010). The training efficacy was measured by the practitioner's utilisation of the new skills and competencies (transfer of training) for six months after the training (Uppal et al., 2010). Uppal et al. (2010) found that the 'transfer of training' can be difficult to achieve in practice, with organisational constraints described as the leading barrier. The paper recommended improvements in the integration of ideology and protocols, regular monitoring of progress, staff incentives, and for staff to explore the practice barriers to the transfer of training (Uppal et al., 2010). These findings highlight the role of ongoing support and supervision in the longer-term transfer of outcomes in ROP training. The REFOCUS/PULSAR project utilised a monthly reflection group to imbed the learning and to allow for the practice of new skills from the program and provided materials for staff to take to supervision (Meadows et al., 2016). The findings from the project showed a small but significant improvement of recovery outcomes in consumers and grow the evidence for ROP. (Meadows et al., 2019). Recovery-oriented supervision is discussed earlier in this report (see p. 14).

The efficacy of ROP practice training is also associated with the utilisation of lived experience facilitators, modelling and knowledge. As Meadows et al. (2019, p. 112) describe, "the involvement of facilitators with lived experience of mental health issues and recovery is central to challenging conventional practices and in making progress towards an effective recovery-oriented mental health workforce". In the Future Horizon (and this report), multiple training programs have been recommended that are coproduced, developed by lived experience professionals or are lived experience preferred programs. The WHO (2021) recommends that training should include human rights, disability, and person-centred approaches in addition to knowledge of recovery.

Microlearning

An approach to workforce development and training in ROP that has been trialled by MHV and other mental health training providers has been the use of microlearning, internet technologies and online training packages. The efficacy of microlearning is an emerging field of research with few studies in the mental health, disability, and ROP contexts. Microlearning "is relatively small, focused learning units consisting of condensed learning activities (usually one to 10 minutes), available on multiple devices" (Shail, 2019, p. 2). The benefits of microlearning are in its accessible format, repetition and condensing of information, short time-commitment, learner participation and flexibility (De Gagne et al., 2019; Shail, 2019). A scoping review of microlearning in health professional education, highlighted the use of microlearning as a refresher or for learning new skills (De Gagne et al., 2019). Notably, there are reported challenges for microlearning in access to technology and internet, development of curriculum, and the low evidence basis (De Gagne et al., 2019; Lee-Fiedler, 2021; Shail, 2019).

Final Recommendations

The Stage Three report recommendations emerge from those presented in the Stage Two Future Horizon report, with some additions and amendments. These proposals aim to strengthen recovery-oriented psychosocial disability support in the NDIS context. A range of actions will be required to enable these recommendations to be implemented, including the commitment of NDIS providers, peak bodies, training providers and government agencies.

1. Workforce development and retention - Training, mentoring, supervision, and support

- Utilise recovery-oriented psychosocial disability support guidelines.
- Provide funded support and supervision for the psychosocial workforce, including communities of practice.
- Introduce funded training programs aligned with ROPDS capabilities for the NDIS psychosocial workforce.
- Provide fundamental ROPDS training to the entire NDIS disability workforce.
- Further the development of micro-credentialling standards for the NDIS workforce.
- Support initiatives to increase workforce retention.

2. Coproduction, lived experience expertise and peer-led services

- Support the lived experience workforce through training and supervision.
- Grow lived experience leadership roles.
- Facilitate the creation of coproduced and peer-led services.

3. Human rights, social justice and choice and control

- Fund and initiate community development and engagement programs to increase social inclusion.
- Enable providers to act as social agents of change and commission coproduced social action initiatives.
- Advocate restructuring NDIS funding packages to increase choice and control, flexibility, and responsiveness.
- Embed a supported decision-making approach for all areas of participant decision-making to promote the rights, autonomy, and self-determination for NDIS participants, their carers and families.

4. Evaluation, accountability, and quality assurance

- Create a nationally consistent feedback process.
- Engage in evaluation and research activities.
- Create and implement psychosocial disability workforce standards.
- Commission a coproduced recovery-oriented psychosocial disability research centre.
- Implement provider credentialling and organisational accreditation processes.

5. Leadership and culture change

- Provide opportunities to celebrate good ROPDS practice.
- Encourage leadership and cultural change in recovery-oriented psychosocial support.
- Create a ROPDS endorsement scheme for providers by relevant peak bodies, e.g. a ‘Recovery-Oriented Tick-of-Approval’.
- Ensure a whole-of-organisation approach to ROP and ROP implementation.

Conclusion

In conclusion, this report has provided a comprehensive update of the Current Landscape and Future Horizon reports, including identified gaps, new and emerging literature and training programs. It has then discussed and synthesised the findings from the National Codesign Workshop Series by MHV, with the Current Landscape and Future Horizon reports. Finally, it has revisited the recommendations for ROPDS in the NDIS context incorporating the new understandings from the National Codesign Workshop Series Phase 1 and 2 reports. This report is the capstone of the *Good Practice in Recovery-Oriented Psychosocial Disability Support* series. The reports have provided the evidence frameworks and assisted the MHV team in their focused work related to *NDIS Recovery-Oriented Psychosocial Delivery Support Project: Growing National Workforce Capability*. The reports will also form the evidence base for the Good Practice Guides to be released by MHV in 2022. MHV intend to complete the ROPDS project work by April 2022.

Glossary of Key Terms

The terminology used in this report has been selected with care to convey respect for the people and groups referenced. In the report, the terminology used is preferred by the NDIS or the Project Reference Group (PRG). Notably, many terms can have multiple definitions or meanings depending on which sector or context they are used. Academic disciplines, stakeholder groups and governing bodies use different terminology over time. The preferred terminology, particularly for specific concepts, has been selected with reference to the literature, where it may differ from the preferred terms.

Capability

"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" (Australian Government Department of Health, 2013b, p. 5).

Codesign

Codesign is the process of working in partnership with consumers to design projects (e.g. programs, services, research) either with professionals or independently (Roper et al., 2018). The phases of codesign are "to define the problem, develop solutions together, and test solutions" (Roper et al., 2018, p. 2).

Community Participation

Community participation refers to having involvement in the everyday world of activities, relationships, community groups or organisations as part of communities of one's choosing – such as neighbourhoods, workplaces, educational and recreational settings, civic groups and so on – rather than in activities that substitute for community involvement (Baron, 2018; Fossey, 2009). In this sense, community participation is intertwined with and central to, experiencing social inclusion.

Consumer

In the mental health context, consumer refers to people who use mental health services, or who may in the future.

Coproduction

Coproduction is the process of working in partnership with consumers at every phase of a project (Roper et al., 2018). These phases include coplanning, codesign, codelivery and coevaluation (Roper et al., 2018). As Roper et al. state "a co-production approach sees consumers involved in, or leading, defining the problem, designing and delivering the solution, and evaluating the outcome, either with professionals or independently" (2018, p. 2).

Culturally and Linguistically Diverse (CALD) Communities

Commonly used to describe people living in Australia from different countries across the world, who speak languages other than English and have diverse cultural backgrounds and/or religious beliefs.

Intersectionality

Intersectionality is a lens that showcases how systems and structures can interact to affect the recovery and general wellbeing of individuals and groups. A participant can have numerous social identities at the same time. A worker needs to consider all of a person's social identities as part of their holistic approach at the same time. This action and lens can assist a worker and participant to see and understand how privilege, power, and oppression shape a person's sense of empowerment, resilience, and wellbeing (Department of Health and Human Services, 2020).

LGBTIQ+

Lesbian, gay, bisexual, transgender, intersex, queer (LGBTIQ+) is the acronym used to indicate sexuality and gender diverse identity groups. LGBTIQ+ "is an umbrella term that refers collectively to an array of distinct sexual orientation and gender identity groups, each with their own unique experiences and health needs" (Mink et al., 2014, p. 504).

Lived Experience

Lived experience refers to "the experience people have of their own or others' mental health challenges, 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" (Australian Government Department of Health, 2013b, p. 33).

Mental Health Condition

Mental health condition is the term used by the NDIS (NDIS, 2018, p. 3) to refer to mental health experiences that may interfere with a person's functioning or ability to lead a happy and easy life.

Participant

In this report, participant refers to consumers who are enrolled in the NDIS instead of people who have engaged in a research project (research participant). Participant is an NDIS-specific term, "a person becomes a participant in the NDIS once the NDIA determines they satisfy the access criteria" (NDIS, 2018, p. 4).

Person Centred Care

Person-centred care is an approach to recovery that focuses on the strengths, uniqueness, and dignity of the individual. Practitioners and consumers work in an equal collaborative partnership to develop self-directed recovery goals, and practitioners support the independence of consumers through responsibility and accountability of people to their own recovery goals. (Also referred to as: Person-centred support, consumer-centred care, consumer-directed care (CDC), person-led care and support)

Psychosocial Disability

Psychosocial disability has been defined by the National Mental Health Consumer & Carer Forum (2011, p. 16) as "the disability experience of people with impairments and participation restrictions related to mental health conditions".

Recovery

There is no single description of recovery because it is by nature a deeply personal lived experience. As stated in Australia's National Framework for Recovery-oriented Services, "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." (Australian Government Department of Health, 2013a, p. 3). Within this framework, recovery is also described 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" (Australian Government Department of Health, 2013b, p. 17).

Furthermore, recovery involves “a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential” (SAMHSA , 2012, p.3). Thus, recovery emerges from hope; is person-driven; occurs via many pathways; is supported by peers and allies; occurs through relationships and social networks; is supported by addressing trauma; involves individual, family and community strengths and responsibility; and is based on respect (SAMHSA, 2012).

Recovery-Oriented Practice

Recovery-oriented practice encapsulates principles and frameworks for practitioners and providers to implement in the delivery of services that promote and support the recovery of participants (Australian Government Department of Health, 2013a).

Social Determinants of Health and Wellbeing

Social determinants of health and wellbeing are the circumstances in a society that influence health and wellbeing, such as housing, transport, education, healthcare, employment, discrimination, stigma, social exclusion, and income security. These circumstances are in turn, driven by wider economic and political forces. Adverse social environments can have a detrimental effect on mental health, and typically people with the lowest socioeconomic status experience the worst mental health outcomes.

Social Inclusion

Social inclusion is often not defined directly but understood as not being socially excluded. So, whereas social exclusion identifies a set of often interconnected conditions that contribute to people becoming marginalized in society (such as low income, unemployment, social isolation, discrimination, disability), social inclusion is linked to notions of belonging, connectedness, social ties and to conventions according full rights as citizens to all people (Sayce, 2000; The United Nations, 2006; Thornicroft, 2006). Therefore, inclusive communities strive to ensure all individuals have equal opportunity to meaningfully participate in their communities and value the diversity that this brings to the community (Salzer & Baron, 2016).

Structural Inequity

Structural inequity refers to a systemic disadvantage for certain groups in society that are caused and maintained by social structures (Weinstein et al., 2017). These social structures include “the policies, economic systems, and other institutions (judicial system, schools, etc.) that have produced and maintain modern social inequities as well as health disparities, often along the lines of social categories such as race, class, gender, sexuality, and ability” (Neff et al., 2020, p. 7, Module 1).

Workforce Capability

Workforce capability “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” (Australian Government Department of Health, 2013b, p. 16).

Acronyms and Abbreviations

CALD	Culturally and linguistically diverse
CoP	Communities of Practice
CRM	Collaborative Recovery Model
DSS	Department of Social Services
LEAG	Lived Experience Advisory Group
MHA	Mental Health Australia
MHCC	Mental Health Coordinating Council
MHV	Mental Health Victoria
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDIS Commission	NDIS Quality and Safeguards Commission
PRG	Project Reference Group
PULSAR	The Principles Unite Local Services Assisting Recovery
RCVMHS	Royal Commission into Victoria's Mental Health System
Recovery Coach	Psychosocial Recovery Coach
ROP	Recovery-oriented practice
ROPDS	Recovery-oriented psychosocial disability support
The Current Landscape	The Current Landscape – Good practice in recovery-oriented psychosocial disability support: Stage One Report
The Future Horizon	The Future Horizon – Good practice in recovery-oriented psychosocial disability support: Stage Two Report

References

Ability Action Australia. (n.d.). Financial autonomy returned. https://abilityactionaustralia.com.au/financial-autonomy-returned/

ALIVE National Centre. (2021). *ALIVE - A National Research Translation Centre to Implement Mental Health Care at Scale in Primary Care and Community Settings*. https://alivenetwork.com.au/

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, *26*(4), 392-407. https://doi.org/10.3109/09540261.2014.928270

Australian Government Department of Health. (2013a). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde

Australian Government Department of Health. (2013b). *A national framework for recovery-oriented mental health services: policy and theory*. https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde

Australian Institute of Health and Welfare. (2020). *Physical health of people with mental illness*. https://www.aihw.gov.au/reports/australias-health/physical-health-of-people-with-mental-illness

Australian Law Reform Commission. (2014). *Equality, Capacity and Disability in Commonwealth Laws* (Report No. 124). https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/5-the-national-disability-insurance-scheme-2/interaction-with-state-and-territory-systems-2/

Baron, R. C. (2018). *Jump-starting community living and participation: A toolkit for promoting participation in community life*. http://www.tucollaborative.org/sdm_downloads/community-inclusion-toolkit-promoting-participation-community-life/

Barwick, M. A., Peters, J., & Boydell, K. (2009). Getting to Uptake: Do Communities of Practice Support the Implementation of Evidence-Based Practice? *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *18*(1), 16–29. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2651208/

Bate, S. P., & Robert, G. (2002). Knowledge management and communities of practice in the private sector: lessons for modernizing the National Health Service in England and Wales. *Public Administration*, *80*(4), 643-663. https://doi.org/10.1111/1467-9299.00322

Bauer, A., Evans-Lacko, S., & Knapp, M. (2019). Valuing recovery-oriented practice at the interface between mental health services and communities: The role of organisational characteristics and environments. *International Journal of Social Psychiatry*, *65*(2), 136-143. https://doi.org/10.1177/0020764019831319

Beer, A., Daniel, L., Baker, E., & Lester, L. (2020). The Shifting Risk of Homelessness among Persons with a Disability: Insights from a National Policy Intervention. *International Journal of Environmental Research and Public Health*, *17*(18), 6512. https://doi.org/10.3390/ijerph17186512

Bennetts, W., Pinches, A., Paluch, T., & Fossey, E. (2013). Real lives, real jobs: Sustaining consumer perspective work in the mental health sector. *Advances in Mental Health*, *11*(3), 313-325. https://doi.org/10.5172/jamh.2013.11.3.313

Bradley, W. J., & Becker, K. D. (2021). Clinical supervision of mental health services: a systematic review of supervision characteristics and practices associated with formative and restorative outcomes. *The Clinical Supervisor*, *40*(1), 88-111. https://doi.org/10.1080/07325223.2021.1904312

Brandow, C. L., Swarbrick, M., & Nemec, P. B. (2020). Rethinking the Causes and Consequences of Financial Wellness for People With Serious Mental Illnesses. *Psychiatric Services*, *71*(1), 89-91. https://doi.org/10.1176/appi.ps.201900323

Brophy, L., Brasier, C., Fossey, E., Whittles, N., & Jacques, M. (2021a). *The Current Landscape: Good practice in recovery-oriented psychosocial disability support. Stage One Report*. Mental Health Victoria. https://www.mhvic.org.au/images/documents/The-Current-Landscape.pdf

Brophy, L., Brasier, C., Fossey, E., Whittles, N., & Jacques, M. (2021b). *The Future Horizon: Good practice in recovery-oriented psychosocial disability support. Stage Two Report*. Mental Health Victoria. https://www.mhvic.org.au/images/documents/The-Future-Horizon.pdf

Brophy, L., Bruxner, A., Wilson, E., Cocks, N., Stylianou, M., & Mitchell, P. (2014). *People making choices: the support needs and preferences of people with psychosocial disability*. https://www.mindaustralia.org.au/sites/default/files/publications/People_making_choices_full_research_report.pdf

Brotherhood of St Laurence. (n.d.-a). *Financial Empowerment & Resilience Network (FERN)*. https://www.bsl.org.au/services/saving-and-managing-money/fern/

Brotherhood of St Laurence. (n.d.-b). *Money Minded*. https://www.bsl.org.au/services/saving-and-managing-money/moneyminded/

Bryant, L., Garnham, B., Tedmanson, D., & Diamandi, S. (2018). Tele-social work and mental health in rural and remote communities in Australia. *International Social Work*, *61*(1), 143-155. https://doi.org/10.1177/0020872815606794

Centre for Mental Health Learning. (n.d.). *Consumer and Family Carer Perspective Supervision Database*. https://supervision.cmhl.org.au/

Chester, P., Ehrlich, C., Warburton, L., Baker, D., Kendall, E., & Crompton, D. (2016). "What is the work of Recovery Oriented Practice? A systematic literature review": What is the work of Recovery Oriented Practice? *International Journal of Mental Health Nursing*, *25*(4), 270-285. https://doi.org/10.1111/inm.12241

Choy-Brown, M., & Stanhope, V. (2018). The Availability of Supervision in Routine Mental Health Care. *Clinical Social Work Journal*, *46*(4), 271-280. https://doi.org/10.1007/s10615-018-0687-0

CLEW. (2021). *Carer Perspective Supervision Framework: A framework for supporting the mental health family/carer lived experience workforce*. https://cmhl.org.au/sites/default/files/resources-pdfs/CPSF_final_digital_compressed%20%28optimized%29.pdf

Commonwealth of Australia. (2019). *Growing the NDIS Market and Workforce: Supporting the market to deliver innovative, people-centred services so that participants can achieve their goals*. https://www.dss.gov.au/sites/default/files/documents/03_2019/220319_-_ndis_market_and_workforce_strategy_acc-_pdf-.pdf

Cosgrove, L., Mills, C., Karter, J. M., Mehta, A., & Kalathil, J. (2020). A critical review of the Lancet Commission on global mental health and sustainable development: Time for a paradigm change. *Critical Public Health*, *30*(5), 624-631. https://doi.org/10.1080/09581596.2019.1667488

Davidson, G., Brophy, L., & Campbell, J. (2016). Risk, Recovery and Capacity: Competing or Complementary Approaches to Mental Health Social Work. *Australian Social Work*, *69*(2), 158-168. https://doi.org/10.1080/0312407x.2015.1126752

Dawson, L., River, J., McCloughen, A., & Buus, N. (2019). 'Should it fit? Yes. Does it fit? No': Exploring the organisational processes of introducing a recovery-oriented approach to mental health in Australian private health care. *Health*, *25*(3), 376-394. https://doi.org/10.1177/1363459319889107

Dawson, M., Phillips, B., & Leggat, S. (2013). Clinical supervision for allied health professionals: a systematic review. *Journal of Allied Health*, *42*(2), 65-73. https://www-ingentaconnect-com.ez.library.latrobe.edu.au/content/asahp/jah/2013/00000042/00000002/art00003#

Dawson, S. (2021). *Community Treatment Orders and Care Planning: A Critical Ethnography* Flinders University]. Adelaide, SA. https://flex.flinders.edu.au/file/d6cad798-f7be-4351-9e36-2c294049005c/1/DawsonThesis2021.pdf

De Gagne, J. C., Park, H. K., Hall, K., Woodward, A., Yamane, S., & Kim, S. S. (2019). Microlearning in Health Professions Education: Scoping Review. *JMIR Medical Education*, *5*(2), e13997. https://doi.org/10.2196/13997

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, *19*(3), 91-97. https://doi.org/10.1037/h0101301

Department of Health and Human Services. (2020). *Allied health capability framework: disability and complex support needs*. State of Victoria. https://www2.health.vic.gov.au/health-workforce/allied-health-workforce/ahcf-disability-complex-support-needs

Department of Social Services. (2020). 1.1.N.03 National Disability Insurance Scheme (NDIS) amount. In *Social Security Guide*. https://guides.dss.gov.au/guide-social-security-law/1/1/n/03

Department of Social Services. (2022). 3.2.6 Tax free pensions or benefits. In *Family Assistance Guide*. https://guides.dss.gov.au/family-assistance-guide/3/2/6

Devine, A., Dickinson, H., Brophy, L., Kavanagh, A., & Vaughan, C. (2021). 'I don't think they trust the choices I will make.' – Narrative analysis of choice and control for people with psychosocial disability within reform of the Australian Disability Employment Services program. *Public Management Review*, *23*(1), 10-30. https://doi.org/10.1080/14719037.2019.1648700

Doroud, N., Fossey, E., Fortune, T., Brophy, L., & Mountford, L. (2021). A journey of living well: a participatory photovoice study exploring recovery and everyday activities with people experiencing mental illness. *Journal of Mental Health*. https://doi.org/10.1080/09638237.2021.1952950

Dudgeon, P., Bray, A., D'Costa, B., & Walker, R. (2017). Decolonising Psychology: Validating Social and Emotional Wellbeing. *Australian Psychologist*, *52*(4), 316-325. https://doi.org/10.1111/ap.12294

Edan, V., Brophy, L., Weller, P. J., Fossey, E., & Meadows, G. (2019). The experience of the use of Community Treatment Orders following recovery-oriented practice training. *International Journal of Law and Psychiatry*, *64*, 178-183. https://doi.org/10.1016/j.ijlp.2019.04.001

Eiroa-Orosa, F. J., & García-Mieres, H. (2019). A Systematic Review and Meta-analysis of Recovery Educational Interventions for Mental Health Professionals. *Administration and Policy in Mental Health and Mental Health Services Research*, *46*(6), 724-752. https://doi.org/10.1007/s10488-019-00956-9

Elbogen, E. B., Tiegreen, J., Vaughan, C., & Bradford, D. W. (2011). Money management, mental health, and psychiatric disability: a recovery-oriented model for improving financial skills. *Psychiatric Rehabilitation Journal*, *34*(3), 223-231. https://doi.org/10.2975/34.3.2011.223.231

Embrace Multicultural Mental Health. (2019). *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*. https://embracementalhealth.org.au/service-providers/framework

Equally Well. (2020). *Our Story*. https://www.equallywell.org.au/our-journey/

ermha365. (n.d.). *Virtual Reality learning resources*. https://www.ermha.org/virtual-reality-learning-resources/

Erondu, C., & McGraw, C. (2021). Exploring the barriers and enablers to the implementation and adoption of recovery-orientated practice by community mental health provider organizations in England. *Social Work in Mental Health*, *19*(5), 457-475. https://doi.org/10.1080/15332985.2021.1949426

Farkas, M., Hutchinson, D., Forbess, R., Restrepo-Toro, M., & Russinova, Z. (2016). *Recovery Promoting Competencies Toolkit*. Boston University Center for Psychiatric Rehabilitation. https://cpr.bu.edu/store/recovery-promoting-competencies-toolkit/

First Peoples Disability Network Australia. (n.d.-a). *Living Our Way*. https://fpdn.org.au/portfolio/living-our-way/

First Peoples Disability Network Australia. (n.d.-b). *Our Films*. https://fpdn.org.au/our-films/

Firth, J., Siddiqi, N., Koyanagi, A., Siskind, D., Rosenbaum, S., Galletly, C., Allan, S., Caneo, C., Carney, R., Carvalho, A. F., Chatterton, M. L., Correll, C. U., Curtis, J., Gaughran, F., Heald, A., Hoare, E., Jackson, S. E., Kisely, S., Lovell, K., . . . Stubbs, B. (2019). The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. *The Lancet Psychiatry*, *6*(8), 675-712. https://doi.org/10.1016/s2215-0366(19)30132-4

Fossey, E. (2009). *Participating as resisting: everyday life stories of people experiencing mental health issues* [Doctoral dissertation, The University of Melbourne].

Fox, J., Ramon, S., & Morant, N. (2015). Exploring the meaning of recovery for carers: Implications for social work practice. *British Journal of Social Work*, *45*(suppl_1), i117-i134. https://doi.org/10.1093/bjsw/bcv109

Frese, F. J., & Walker Davis, W. (1997). The Consumer–Survivor Movement, Recovery, and Consumer Professionals. *Professional Psychology-Research and Practice*, *28*(3), 243-245. https://doi.org/10.1037/0735-7028.28.3.243

Gabrielsson, S., & Looi, G.-M. E. (2019). Recovery-Oriented Reflective Practice Groups: Conceptual Framework and Group Structure. *Issues in Mental Health Nursing*, *40*(12), 993-998. https://doi.org/10.1080/01612840.2019.1644568

Gajaria, A., Izenberg, J. M., Nguyen, V., Rimal, P., Acharya, B., & Hansen, H. (2019). Moving the Global Mental Health Debate Forward: How a Structural Competency Framework Can Apply to Global Mental Health Training. *Academic Psychiatry*, *43*(6), 617-620. https://doi.org/10.1007/s40596-019-01073-3

Gammon, D., Strand, M., Eng, L. S., Børøsund, E., Varsi, C., & Ruland, C. (2017). Shifting Practices Toward Recovery-Oriented Care Through an E-Recovery Portal in Community Mental Health Care: A Mixed-Methods Exploratory Study. *Journal of Medical Internet Research*, *19*(5), e145. https://doi.org/10.2196/jmir.7524

Gee, M., Bhanbhro, S., Cook, S., & Killaspy, H. (2016). Rapid realist review of the evidence: achieving lasting change when mental health rehabilitation staff undertake recovery-oriented training. *Journal of Advanced Nursing*, *73*(8), 1775–1791. https://doi.org/10.1111/jan.13232

Gee, M., Bhanbhro, S., Cook, S., & Killaspy, H. (2017). Rapid realist review of the evidence: achieving lasting change when mental health rehabilitation staff undertake recovery-oriented training. *Journal of Advanced Nursing*, *73*(8), 1775-1791. https://doi.org/10.1111/jan.13232

Hamilton, D., Hancock, N., Scanlan, J. N., & Banfield, M. (2020). The National Disability Insurance Scheme and people with severe and persistent mental illness/psychosocial disability: A review, analysis and synthesis of published literature. *Australian & New Zealand Journal of Psychiatry*, *54*(12), 1162-1172. https://doi.org/10.1177/0004867420967747

Hansen, H., Braslow, J., & Rohrbaugh, R. M. (2018). From Cultural to Structural Competency—Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism. *JAMA Psychiatry*, *75*(2), 117. https://doi.org/10.1001/jamapsychiatry.2017.3894

Harper, A., Clayton, A., Bailey, M., Foss-Kelly, L., Sernyak, M. J., & Rowe, M. (2015). Financial Health and Mental Health Among Clients of a Community Mental Health Center: Making the Connections. *Psychiatric Services*, *66*(12), 1271-1276. https://doi.org/10.1176/appi.ps.201400438

Harper, A., Staeheli, M., Edwards, D., Herring, Y., & Baker, M. (2018). Disabled, Poor, and Poorly Served: Access to and Use of Financial Services by People with Serious Mental Illness. *Social Service Review*, *92*(2), 202-240. https://doi.org/10.1086/697904

Health Education and Training Institute. (2012). *The superguide: a handbook for supervising allied health professionals*. https://www.heti.nsw.gov.au/__data/assets/pdf_file/0005/424859/HETI_Superguide_Txt_WARA HETI_OCT_19.pdf

Health Workforce Australia. (2014). *National Clinical Supervision Competency Resource*. https://humancapitalalliance.com.au/wp-content/uploads/2013/01/HWA_National-Clinical-Supervision-Competency-Resource_FINAL_LR_0_0.pdf

Jackson-Blott, K., Hare, D., Davies, B., & Morgan, S. (2019). Recovery-oriented training programmes for mental health professionals: A narrative literature review. *Mental Health & Prevention*, *13*, 113-127. https://doi.org/10.1016/j.mhp.2019.01.005

Jiménez-Solomon, O. G., Méndez-Bustos, P., Swarbrick, M., Díaz, S., Silva, S., Kelley, M., Duke, S., & Lewis-Fernández, R. (2016). Peer-Supported Economic Empowerment: A Financial Wellness Intervention Framework for People With Psychiatric Disabilities. *Psychiatric Rehabilitation Journal*, *39*(3), 222–233. https://doi.org/10.1037/prj0000210

Jones, J., Fairchild, J., Carman, M., Kennedy, P., Joseph, S., & Parsons, M. (2020). *Rainbow Tick Standards: A framework for LGBTIQ cultural safety*. Rainbow Health Victoria. https://rainbowhealthaustralia.org.au/media/pages/rainbow-tick/3214906303-1638424206/rainbow-tick-standards-a-framework-for-lgbtiq-cultural-safety.pdf

Karban, K. (2017). Developing a Health Inequalities Approach for Mental Health Social Work. *British Journal of Social Work*, 885–902. https://doi.org/10.1093/bjsw/bcw098

Klevan, T., Jonassen, R., Topor, A., & Borg, M. (2021). Mutual learning: exploring collaboration, knowledge and roles in the development of recovery-oriented services. A hermeneutic-phenomenological study. *International Journal of Qualitative Studies on Health and Well-being*, *16*(1). https://doi.org/10.1080/17482631.2021.2001898

La Trobe University. (2021a). *The Suicide Response Project*. www.suicideresponseproject.com

La Trobe University. (2021b). *Website to help prevent suicide* https://www.latrobe.edu.au/news/articles/2021/release/website-to-help-prevent-suicide?referrer=organic_social&referrertype=linkedin

Lalley, N. A., Manger, S. H., Jacka, F., Rocks, T., Ruusunen, A., & Barron, L. (2021). The Mind-Body Well-being Initiative: a better lifestyle for people with severe mental illness. *Australasian Psychiatry*, *29*(4), 434-438. https://doi.org/10.1177/1039856220978864

Lamonica, H. M., Milton, A., Braunstein, K., Rowe, S. C., Ottavio, A., Jackson, T., Easton, M. A., Hambleton, A., Hickie, I. B., & Davenport, T. A. (2020). Technology-Enabled Solutions for Australian Mental Health Services Reform: Impact Evaluation. *JMIR Formative Research*, *4*(11), e18759. https://doi.org/10.2196/18759

Lee-Fiedler, J. (2021). *Nurse educators' experiences using microlearning strategies: A basic qualitative study* [Dissertation, Capella University]. ProQuest One Academic. http://ez.library.latrobe.edu.au/login?url=https://www.proquest.com/dissertations-theses/nurse-educators-experiences-using-microlearning/docview/2596387607/se-2?accountid=12001

Light, E., Kerridge, I., Ryan, C., & Robertson, M. (2012). Community treatment orders in Australia: rates and patterns of use. *Australasian Psychiatry*, *20*(6), 478-482. https://doi.org/10.1177/1039856212466159

Lorien, L., Blunden, S., & Madsen, W. (2020). Implementation of recovery-oriented practice in hospital-based mental health services: A systematic review. *International Journal of Mental Health Nursing*, *29*(6), 1035-1048. https://doi.org/10.1111/inm.12794

Mackay, T., Loughhead, M., & Goodwin-Smith, I. (2019). *UnitingSA NDIS Peer Support Program*. https://unitingsa.com.au/wp-content/uploads/2020/06/UnitingSA-NDIS-Peer-Support-Program-Evaluation-Report_FINAL.pdf

Marston, G., Cowling, S., & Bielefeld, S. (2016). Tensions and contradictions in Australian social policy reform: compulsory Income Management and the National Disability Insurance Scheme. *Australian Journal of Social Issues*, *51*(4), 399-417. https://doi.org/10.1002/j.1839-4655.2016.tb01240.x

Maybery, D., Jaffe, I. C., Cuff, R., Duncan, Z., Grant, A., Kennelly, M., Ruud, T., Skogoy, B. E., Weimand, B., & Reupert, A. (2021). Mental health service engagement with family and carers: what practices are fundamental? *BMC Health Services Research*, *21*(1). https://doi.org/10.1186/s12913-021-07104-w

McGough, S., Wynaden, D., & Wright, M. (2018). Experience of providing cultural safety in mental health to Aboriginal patients: A grounded theory study. *International Journal of Mental Health Nursing*, *27*(1), 204-213. https://doi.org/10.1111/inm.12310

McKenna, B., Oakes, J., Fourniotis, N., Toomey, N., & Furness, T. (2016). Recovery-Oriented Mental Health Practice in a Community Care Unit: An Exploratory Study. *J Forensic Nurs*, *12*(4), 167-175. https://doi.org/10.1097/JFN.0000000000000127

Meadows, G., Agis, U., Barnfield, J., Brooker, J., Brophy, L., Clarke, D., Edan, V., Fossey, E., Grigg, M., Inder, B., Julian, J., Kakuma, R., Mazza, D., Minas, I.-H., Murphy, B., Russell, G., Slade, M., Thornton-Gaylard, C., Weller, P., & Wilson-Evered, E. (2016). *PULSAR Manual: Recovery-promoting relationships and working practices for specialist and community mental health services (or Secondary Care staff)* (2 ed.). Monash University. https://www.monash.edu/__data/assets/pdf_file/0017/1452410/PULSAR-Secondary_Care_Manual-FINAL.pdf

Meadows, G., Brophy, L., Shawyer, F., Enticott, J. C., Fossey, E., Thornton, C. D., Weller, P. J., Wilson-Evered, E., Edan, V., & Slade, M. (2019). REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial. *The Lancet Psychiatry*, *6*(2), 103-114. https://doi.org/10.1016/s2215-0366(18)30429-2

Mental Health Carers NSW. (2022). *MHCN Training Schedule* https://www.mentalhealthcarersnsw.org/training/

Mental Health Coordinating Council. (2016). *Guideline for Establishing a Local NDIS Community of Practice to Enhance Learning and Sector Reform*. https://www.mhcc.org.au/wp-content/uploads/2018/05/ndis_cop_guidelines_final_200117.pdf

Mental Health Coordinating Council. (2021a). LGBTIQ+ people and mental health conditions. In *Mental Health Rights Manual*. https://mhrm.mhcc.org.au/chapters/8-people-with-mental-health-and-co-existing-conditions/8i-lgbtiq-people-and-mental-health-conditions/

Mental Health Coordinating Council. (2021b). *Reimagine Stage 2 Project: Findings from Priority Population Co-Design Groups*.

Mental Health Coordinating Council. (2021c). *Supported Decision-Making Modules 1 and 2*. https://mhcc.learningcart.com/products/Supported-Decision-Making-Modules-1-and-2.aspx?_cldee=Y29yaW5uZUBtaGNjLm9yZy5hdQ%3d%3d&recipientid=contact-ac00f076d3ede211b0511cc1de6daa0b-281483768c3f46e3a7201460820f13ae&esid=abc2dfd2-3f2d-ec11-b6e6-002248156e88

Mental Health Victoria. (2018). *Project: Recovery-oriented practice resources for providing NDIS psychosocial supports*. https://www.mhvic.org.au/images/PDF/Policy/181205-Project_FINAL_REPORT_Discussion_Paper.pdf

Mental Health Victoria. (2020). *MHV NDIS Workforce Development (Psychosocial Capabilities) Project*. https://www.mhvic.org.au/images/PDF/Training/Projects/Fact_Sheet_Project_Summary_v7.pdf

Mental Health Victoria. (2021a). *Phase 1 Workshops: Thoughts and Experiences About NDIS Psychosocial Support - Participant and Carer Feedback, National Codesign Workshop Series, Recovery Oriented Psychosocial Disability Support (ROPDS) Project – Growing National Workforce Capability*. https://www.mhvic.org.au/images/PDF/ROPDS/ROPDS_Codesign_Report_Phase_1_participants-carers.pdf

Mental Health Victoria. (2021b). *Phase 2 Workshops: Thoughts and Experiences of the Psychosocial Workforce - Worker and Provider Feedback, Recovery Oriented Psychosocial Disability Support (ROPDS) Project – Growing National Workforce Capability*. https://www.mhvic.org.au/images/PDF/ROPDS/ROPDS_Codesign_Report_Phase_2_worker-provider.pdf

Milne, D. (2007). An empirical definition of clinical supervision. *British Journal of Clinical Psychology*, *46*(4), 437-447. https://doi.org/10.1348/014466507x197415

Mind Australia, & Helping Minds. (2016). *A practical guide for working with carers of people with a mental illness*. Mind Australia, Helping Minds, P. M. Health, Consumer Carer Network (Australia), Mental Health Carers Arafmi Australia, & Mental Health Australia. https://www.tandemcarers.org.au/images/A_practical_guide_for_working_with_people_with_a_mental_illness.pdf

Mink, M. D., Lindley, L. L., & Weinstein, A. A. (2014). Stress, stigma, and sexual minority status: The intersectional ecology model of LGBTQ health. *Journal of Gay & Lesbian Social Services*, *26*(4), 502-521. https://doi.org/10.1080/10538720.2014.953660

Morgan, M., Peters, D., Hopwood, M., Castle, D., Moy, C., Fehily, C., Sharma, A., Rocks, T., Mc Namara, K., Cobb, L., Duggan, M., Dunbar, J. A., & Calder, R. V. (2021). *Being Equally Well: A National Policy Roadmap to Better Health Care and Longer Lives for People Living with Serious Mental Illness*. https://www.vu.edu.au/sites/default/files/being-equally-well-policy-roadmap-mitchell-institute.pdf

National Disability Insurance Scheme Act 2013 (Cth).

National Disability Services. (2019). NDIS market dynamics study National Disability Services Victorian NDIS sector development project. https://www.nds.org.au/item/ndis-market-dynamics-nds-releases-new-research-on-victorian-disability-services-sector

National LGBTI Health Alliance. (2013). *Inclusive Language Guide*. https://d3n8a8pro7vhmx.cloudfront.net/lgbtihealth/pages/670/attachments/original/1587966204/Alliance_Health_Information_Sheet_Inclusive_Language_Guide_on_Intersex__Trans_and_Gender_Diversity_0.pdf?1587966204

NDIS. (2018). *Glossary: Key terms for understanding the NDIS and psychosocial disability*. https://www.ndis.gov.au/media/119/download

NDIS. (2020a). *Employment outcomes for NDIS participants* https://data.ndis.gov.au/media/2815/download?attachment

NDIS. (2020b). *Guardians and nominees explained*. https://www.ndis.gov.au/understanding/families-and-carers/guardians-and-nominees-explained

NDIS. (2021a). *Plan management*. https://www.ndis.gov.au/participants/creating-your-plan/ways-manage-your-funding/plan-management

NDIS. (2021b). *Support budgets in your plan*. https://www.ndis.gov.au/participants/using-your-plan/managing-your-plan/support-budgets-your-plan

NDIS Quality and Safeguards Commission. (2021). *NDIS Workforce Capability Framework*. https://workforcecapability.ndiscommission.gov.au/sites/default/files/Resources/2021-10/NDIS-Workforce-Capability-Framework.pdf

Neff, J., Holmes, S. M., Knight, K. R., Strong, S., Thompson-Lastad, A., McGuinness, C., Duncan, L., Saxena, N., Harvey, M. J., Langford, A., Carey-Simms, K. L., Minahan, Sara N., Satterwhite, S., Ruppel, C., Lee, S., Walkover, L., De Avila, J., Lewis, B., Matthews, J., & Nelson, N. (2020). Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities. *MedEdPORTAL*, *16*. https://doi.org/doi:10.15766/mep_2374-8265.10888

Office of the Public Guardian. (2017). *Joint Standing Committee on the NDIS: Submission to the inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*. https://www.publicguardian.qld.gov.au/__data/assets/pdf_file/0004/576049/sub-joint-standing-committee-ndis-inquiry-into-psychosocial-disabilities.pdf

PHN North Western Melbourne. (2020). *National LGBTIQ suicide prevention trial*. https://nwmphn.org.au/our-work/suicide-prevention-intervention/lgbtiq-suicide-prevention/

Piat, M., Briand, C., Bates, E., & Labonté, L. (2016). Recovery Communities of Practice: An Innovative Strategy for Mental Health System Transformation. *Psychiatric Services*, *67*(1), 10-12. https://doi.org/10.1176/appi.ps.201500184

Productivity Commission. (2019). *Mental Health: Productivity Commission draft report (volume 1)*. Commonwealth of Australia.

Productivity Commission. (2020). *Mental Health Inquiry Report* (95). https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf

Queensland Health. (2009). *Clinical Supervision Guidelines for Mental Health Services*. https://www.health.qld.gov.au/__data/assets/pdf_file/0026/371627/superguide_2009.pdf

Quinn, A., Ji, P., & Nackerud, L. (2018). Predictors of secondary traumatic stress among social workers: Supervision, income, and caseload size. *Journal of Social Work*, *19*(4), 504-528. https://doi.org/10.1177/1468017318762450

Ranmuthugala, G., Plumb, J. J., Cunningham, F. C., Georgiou, A., Westbrook, J. I., & Braithwaite, J. (2011). How and why are communities of practice established in the healthcare sector? A systematic review of the literature. *BMC Health Services Research*, *11*(1), 273. https://doi.org/10.1186/1472-6963-11-273

Roper, C., Edan, V., & Daya, I. (2021). *Foundations in Consumer Perspective Work*. Athena Consulting. https://www.eventbrite.com.au/e/2-day-foundations-in-consumer-perspective-work-registration-168885476005

Roper, C., Grey, F., & Cadogan, E. (2018). *Co-production: Putting principles into practice in mental health contexts*. University of Melbourne. https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf

Rowe, M., & Davidson, L. (2016). Recovering Citizenship. *The Israel Journal of Psychiatry and Related Sciences*, *53*(1), 14-21. https://www.proquest.com/docview/1830058147/fulltextPDF/3400565F97824435PQ/1?accountid=12001

Royal Commission into Victoria's Mental Health System. (2021). *Royal Commission into Victoria's Mental Health System*. State of Victoria.

Rugkåsa, J. (2016). Effectiveness of Community Treatment Orders: The International Evidence. *The Canadian Journal of Psychiatry*, *61*(1), 15-24. https://doi.org/10.1177/0706743715620415

Russell, R., Kutin, J., Stewart, M., & Rankin, G. (2017). *MoneyMinded Impact Report*. Australia and New Zealand Banking Group (ANZ) & RMIT University. https://www.financialcapability.gov.au/files/mm-impact-2017.pdf

SA Health. (2014). *Allied Health Clinical Supervision Framework*. https://www.sahealth.sa.gov.au/wps/wcm/connect/ad788900438bd2b689308dfd37f1549d/ASH+Clin+Super+Framework+2014.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-ad788900438bd2b689308dfd37f1549d-n5iGlnT

Salzer, M. S., & Baron, R. C. (2016). *Well Together – A blueprint for community inclusion: fundamental concepts, theoretical frameworks and evidence*. https://media.wellways.org/inline-files/Well%20Together.pdf

SAMHSA. (2012). Working Definition of Recovery. https://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF

Sayce, L. (2000). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion*. St Martin's Press. https://doi.org/10.1007/978-1-349-27833-6

Scholz, B., Bocking, J., & Happell, B. (2017). How do consumer leaders co-create value in mental health organisations? *Australian Health Review*, *41*(5), 505. https://doi.org/10.1071/ah16105

Shail, M. S. (2019). Using Micro-learning on Mobile Applications to Increase Knowledge Retention and Work Performance: A Review of Literature. *Cureus*. https://doi.org/10.7759/cureus.5307

Shera, W., & Ramon, S. (2013). Challenges in the implementation of recovery-oriented mental health policies and services: analysis of developments in England and Canada. *International Journal of Mental Health*, *42*(2-3), 17-42. https://doi.org/10.2753/IMH0020-7411420202

Shor, R., & Shalev, A. (2014). Barriers to involvement in physical activities of persons with mental illness. *Health Promotion International*, 116-123. https://doi.org/10.1093/heapro/dau078

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, *13*(1), 12-20. https://doi.org/10.1002/wps.20084

Sowers, W., Primm, A., Cohen, D., Pettis, J., & Thompson, K. (2016). Transforming psychiatry: A curriculum on recovery-oriented care. *Academic Psychiatry*, *40*(3), 461-467.

State Government of Victoria. (2021). *LGBTIQ Inclusive Language Guide*. https://www.vic.gov.au/inclusive-language-guide

State of Victoria. (2018a). *Clinical supervision for mental health nurses: A framework for Victoria*. Department of Health and Human Services. https://www2.health.vic.gov.au/mental-health/chief-mental-health-nurse/clinical-supervision-framework

State of Victoria. (2018b). *Supervision and delegation framework for allied health assistants and the support workforce in disability*. State of Victoria Department of Health and Human Services. https://www2.health.vic.gov.au/-/media/health/files/collections/policies-and-guidelines/a/allied-health-in-disability---supervision-and-delegation-framework.pdf?la=en&hash=17C8B0DA1306D5944508699B58349590B1BE4CCA

State of Victoria. (2019). *Victorian Allied Health Clinical Supervision Framework*. State of Victoria Department of Health and Human Services. https://www2.health.vic.gov.au/health-workforce/allied-health-workforce/clinical-supervision-framework

State of Victoria. (2021). *Understanding the workforce experience of the NDIS: longitudinal research project - Year three*. Department of Families Fairness and Housing. https://content.vic.gov.au/sites/default/files/2021-09/NDIS-Workforce-Longitudinal-Research-Study-2020.PDF

Sugiura, K., Mahomed, F., Saxena, S., & Patel, V. (2020). An end to coercion: rights and decision-making in mental health care. *Bulletin of the World Health Organization*, *98*(1), 52-58. https://doi.org/10.2471/blt.19.234906

The United Nations. (2006). Convention on the Rights of Persons with Disabilities. *Treaty Series*, *2515*(3). https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html

Thomas, E. C., Despeaux, K. E., Drapalski, A. L., & Bennett, M. (2018). Person-Oriented Recovery of Individuals With Serious Mental Illnesses: A Review and Meta-Analysis of Longitudinal Findings. *Psychiatric Services*, *69*(3), 259-267. https://doi.org/10.1176/appi.ps.201700058

Thornicroft, G. (2006). *Shunned: Discrimination against people with mental illness*. Oxford University Press.

Topor, A., Bøe, T. D., & Larsen, I. B. (2018). Small things, micro-affirmations and helpful professionals everyday recovery-orientated practices according to persons with mental health problems. *Community Mental Health Journal*, *54*(8), 1212-1220. https://doi.org/10.1007/s10597-018-0245-9

Uppal, S., Oades, L. G., Crowe, T. P., & Deane, F. P. (2010). Barriers to transfer of collaborative recovery training into Australian mental health services: implications for the development of evidence-based services. *Journal of Evaluation in Clinical Practice*. https://doi.org/10.1111/j.1365-2753.2009.01141.x

VicHealth. (2014). *Enabling Health: Taking action to improve the health of people with a disability*. Victorian Health Promotion Foundation & VicHealth. https://www.vichealth.vic.gov.au/~/media/ResourceCentre/PublicationsandResources/Health%20Inequalities/EnablingHealth/vic082-EnablingHealth-Pages-WEB%2003.ashx

Victorian Mental Illness Awareness Council, & Centre for Psychiatric Nursing. (2018). *Consumer Perspective Supervision project: A framework for supporting the consumer workforce*. https://cmhl.org.au/sites/default/files/resources-pdfs/RESOURCE%20consumer%20perspective%20supervision%20summary%20of%20resources%20final.PDF

VMIAC. (2020). *Submission: General issues around implementation and performance of the NDIS*. https://www.vmiac.org.au/wp-content/uploads/VMIAC_Joint-Standing-Committee_NDIS-General-Issues-Submission-Oct-2020-3-1-1.pdf

VMIAC. (n.d.). *Supported decision-making*. https://www.vmiac.org.au/wp-content/uploads/Supported-Decision-Making.pdf

Weikel, K., Tomer, A., Davis, L., & Sieke, R. (2017). Recovery and self-efficacy of a newly trained certified peer specialist following supplemental weekly group supervision: A case-based time-series analysis. *American Journal of Psychiatric Rehabilitation*, *20*(1), 1-15. https://doi.org/10.1080/15487768.2016.1267051

Weinstein, J. N., Baciu, A., Negussie, Y., & Geller, A. (2017). The Root Causes of Health Inequity. In J. N. Weinstein, A. Baciu, Y. Negussie, & A. Geller (Eds.), *Communities in Action: Pathways to Health Equity*. National Academies Press. https://doi.org/10.17226/24624

Williams, A., Farhall, J., Fossey, E., & Thomas, N. (2019). Internet-based interventions to support recovery and self-management: A scoping review of their use by mental health service users and providers together. *BMC Psychiatry*, *19*(1), 191. https://doi.org/10.1186/s12888-019-2153-0

Wilson, E., Campain, R., Pollock, S., Brophy, L., & Stratford, A. (2021). Exploring the personal, programmatic and market barriers to choice in the NDIS for people with psychosocial disability. *Australian Journal of Social Issues*. https://doi.org/10.1002/ajs4.154

Wimpenny, K., Forsyth, K., Jones, C., Matheson, L., & Colley, J. (2010). Implementing the Model of Human Occupation across a Mental Health Occupational Therapy Service: Communities of Practice and a Participatory Change Process. *British Journal of Occupational Therapy*, *73*(11), 507-516. https://doi.org/10.4276/030802210x12892992239152

Winsper, C., Crawford-Docherty, A., Weich, S., Fenton, S.-J., & Singh, S. P. (2020). How do recovery-oriented interventions contribute to personal mental health recovery? A systematic review and logic model. *Clinical Psychology Review*, *76*, 101815. https://doi.org/10.1016/j.cpr.2020.101815

World Health Organisation. (2019). *WHO QualityRights guidance module: Advocacy for mental health, disability and human rights*. https://apps.who.int/iris/bitstream/handle/10665/329587/9789241516792-eng.pdf

World Health Organization. (2019a). *Quality Rights materials for training, guidance and transformation*. World Health Organization. https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools

World Health Organization. (2019b). *Recovery and the right to health. WHO QualityRights Core training: mental health and social services, course guide*. https://apps.who.int/iris/bitstream/handle/10665/329577/9789241516723-eng.pdf

World Health Organization. (2019c). *Recovery practices for mental health and well-being: WHO QualityRights specialized training, course guide*. https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools

World Health Organization. (2021). *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-health-services

Yerushalmi, H., & Lysaker, P. H. (2014). The Recovery Approach to Rehabilitation: Implementation in Supervision. *Journal of Social Work Practice*, *28*(1), 59-73. https://doi.org/10.1080/02650533.2013.828277