LA TROBE UNIVERSITY

MentalHealth Victoria
Collaboration • Knowledge • Leadership
mhvic.org.au

THE CURRENT LANDSCAPE

Good Practice in Recovery-Oriented Psychosocial Disability Support

Stage One Report

September 2021

Authors

Prof. Lisa Brophy
Principal Investigator
Discipline Lead
Social Work and Social Policy
La Trobe University

Dr. Catherine Brasier
Co-Investigator
Post-Doctoral Research Fellow
Social Work and Social Policy
La Trobe University

Prof. Ellie Fossey
Co-Investigator
Head of Department
Occupational Therapy
Monash University

Nina Whittles
Research Assistant
Social Work and Social Policy
La Trobe University

Megan Jacques
Research Assistant
Social Work and Social Policy
La Trobe University

Acknowledgements

Our thanks to the project team at Mental Health Victoria and the Project Reference Group for their advice and guidance.

Mental Health Victoria (MHV) Project team
Kieran Halloran, Manager Psychosocial Projects,
Anthea Gellie, Senior Project Officer,
Louise Alexander, Senior Project Officer, and
David McGuire, Director, Workforce Development and Learning.

NDIS ROPDS Project Reference Group (PRG)
Simon De Sousa, Bill Gye, Dianne Hardy, Kerry Hawkins, Erandathie Jayakody, Harry Lovelock, Janet Milford, Malitha Perera, Lachlan Rodenburg and Neil Turton-Lane.

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

Chapter One: Introduction

NDIS Recovery-Oriented Psychosocial Disability Support – Growing National Workforce Capability

This report is the first of two reports being prepared as part of a broader project titled the *National Disability Insurance Scheme (NDIS) Recovery-Oriented Psychosocial Disability Support (ROPDS) - Growing National Workforce Capability Project* ('the Project').

A key deliverable of the Project is a Literature Review and a Synthesis Report regarding good practice in recovery-oriented psychosocial practice service provision contextualised to the National Disability Insurance Scheme (NDIS) environment. The Literature Review and Synthesis Report is divided into two stages: Stage One – *The Current Landscape*; and Stage Two – *The Future Horizon.*

The Current Landscape reports on Stage One of the Project and provides a summary of a literature review that focused on the history of recovery; recovery-oriented practice; the current practice environment, and key considerations for Stage Two of the Project. *The Future Horizon* will report on Stage Two, providing information to guide the NDIS ROPDS Project team in developing a consistent national picture of the recovery-oriented capabilities required for psychosocial disability support workers. Stage Two will build on what we have learnt from the Stage One review and will more directly explore how to address the barriers and workforce-related issues impacting on effective recovery-oriented practice for NDIS participants with psychosocial supports in their plans.

Background

The following report synthesises literature from leading recovery-oriented practice perspectives relevant to psychosocial disability supports. The literature informing this report is from current research, leading policy documents, peak body guidelines and frameworks from across the mental health landscape, focusing on psychosocial disability and recovery-oriented practice. Overall, the literature review found a paucity of research about personalised funding interventions for people with psychosocial disability, both in relation to the NDIS, and equivalent approaches internationally. A systematic review of NDIS and psychosocial disability by Hamilton et al. (2020) had a similar finding, with limited papers found in the search. This was also a finding of Fleming et al. (2019), who reviewed the research on individualised funding interventions for people with psychosocial disability.

The questions and tasks that guided our investigation of *The Current Landscape* were:

a. What does good recovery-oriented practice look like?
b. Recovery and the NDIS: How do NDIS policies and frameworks describe psychosocial recovery?
c. Comparison of other (or overlapping) concepts of recovery-oriented practice across all disability groups and key population groups including CALD, Aboriginal and Torres Strait Islander, and LGBTIQ+.
d. How is Recovery-Oriented Psychosocial Disability Support operating in the current NDIS environment?
e. Are there barriers to developing effective Recovery-Oriented Psychosocial Disability Support?
f. Provide recommendations as to what Stage Two should investigate further.

Chapter Two: Stage One Findings

The History of Recovery

This section introduces the history of recovery. An exploration of recovery-oriented practice benefits from an understanding of 'recovery' and its historical origins. The recovery approach is an important paradigm that is influencing the mental health landscape, and shapes the understanding of recovery-oriented mental health practice and service delivery (Lloyd et al., 2006). The next section will introduce recovery-oriented practice in the NDIS context.

Defining Recovery

The term recovery is widely used, although there is no consensus regarding its definition. This may in part be due to recovery being identified as a deeply personal experience which is unique to each individual (Australian Government Department of Health, 2013; Onken et al., 2007). This is accepted in Australian government literature which states that "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, 2013, p. 3).

However, there a number of definitions that are commonly referred to that have sought to encompass the essence of 'recovery'. The definition by Anthony (1993, p. 15) is commonly referenced in the recovery literature and states:

> A person with mental illness can recover even though the illness is not 'cured'… Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

The following definition by Deegan (1996, pp. 96-97) is regarded as important by many in the consumer movement because of how fundamentally it values lived experience:

> Recovery does not mean cure. Rather recovery is an attitude, a stance, and a way of approaching the day's challenges. It is not a perfectly linear journey. There are times of rapid gains and disappointing relapses. There are times of just living, just staying quiet, resting and regrouping. Each person's journey of recovery is unique. Each person must find what works for them. This means that we must have the opportunity to try and to fail and to try again. In order to support the recovery process mental health professionals must not rob us of the opportunity to fail.

Despite the differences in the definitions, both Deegan (1996) and Anthony (1993) captured the understanding that 'recovery' does not align with the dominant bio-medical models' concept of 'cured'. Both definitions capture the ideas and values articulated in consumers' first-person accounts of finding or being on a journey of personal recovery. This is an important contrast to the messaging often experienced by consumers which reinforce a sense of hopelessness (Ostrow & Adams, 2012).

Defining Recovery and Psychosocial Disability in the NDIS

Recovery is currently defined by the National Disability Insurance Scheme (n.d., p. 1) as:

> Achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with, or recovering from, a mental health condition.

It is argued that recovery has the potential to be strongly linked to the aspirations of the NDIS. As the NDIS is designed to enable people with support needs likely to be permanent due to the nature of their disability, including psychosocial disability, the opportunity "to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports" (NDIS Independent Advisory Council, 2013, p. 1).

The NDIS provides support to individuals with a psychosocial disability as a part of their recovery journey. 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".

How Recovery Came to be Defined

Consumers' first-person accounts and the consumer/survivor movement were instrumental in defining recovery (Deegan, 1996). Advocating for human rights, challenging discrimination, and the deficit model was also key (Ostrow & Adams, 2012; Ramon et al., 2007). The consumer/survivor movement emerged in Australia and internationally during the 1980s and 1990s during which time advocates worked to bring recovery to the forefront of the national conversation about mental health. Since the 1990s, recovery has been a key feature of Australian consumer groups, including the Victorian Mental Illness Awareness Council (VIMIAC), and the National Mental Health Consumer and Carer Forum, as well as various non-government organisations (Ramon et al., 2007).

Key facets of recovery include hope, personal responsibility, identity, education, advocacy, and peer support (Mead & Copeland, 2000). The aspects relating to hope and peer support highlight how heavily informed recovery is by lived experience perspectives and peer support work. People with lived experience have played a crucial role in advocating for person-centred services, choice and control, self-determination, and a focus on having a meaningful life.

Recovery incorporates aspects of lived experience that transcend the clinical treatment of mental health conditions with a focus on meaning and connection (Anthony, 1993). Recovery involves honouring people's right to access the opportunities and resources to enable them to lead meaningful lives (as defined by them), and to re-define what their life means (Henwood et al., 2015). It is important for a mental health support worker to consider how having limited resources and the absence of basic necessities impacts a person's recovery journey (Henwood et al., 2015). Basic needs, such as being safe, secure, affordable housing financial security; respect for human rights; and the absence of violence are enablers for peoples recovery journey (Allen et al., 2014; Australian Government Department of Health, 2013; Fisher & Baum, 2010). These dimensions of recovery align with the concepts underpinning the social determinants of mental health. Another vital dimension to recovery acknowledges the fundamental need for social connections, including to have love, intimacy, family, and friends (Commission on Social Determinants of Health, 2008). The 'social connection needs' dimension requires the worker to consider whether people have access to an informal network of family, friends and other supporters – and their subjective experience of loneliness (Productivity Commission, 2020). The process of restoring relations and establishing connections to the community underpins social and relational recovery theory and is a crucial part of each person's recovery journey.

Hayes et al. (2018) linked psychosocial disability support to social models of disability by recognising that the social determinants (such as stigma, social exclusion, and discrimination) contribute to people's experience of disability and impacts on their recovery. The ability to function in daily life and participate in community activities, including employment, are important considerations when supporting people with psychosocial disability in their recovery journey (Hayes et al., 2018).

Aboriginal and Torres Strait Islander Communities Perspectives on Recovery

In Aboriginal and Torres Strait Islander communities, mental health and wellbeing are commonly conceptualised within a holistic framework of social and emotional wellbeing (SEWB):

> Healing is one of the most common ways of understanding Aboriginal peoples' experience of recovery from trauma and other mental health and social and emotional wellbeing difficulties, including unresolved grief and loss. The concept of Aboriginal health and wellbeing is different to the universal concept as it is regarded and recognised as a more holistic and whole-of-life view. It encompasses the social, emotional and cultural wellbeing of not only the individual, but the wider community thereby bringing about the total wellbeing of community (State of Victoria Department of Health and Human Services, 2017, p. 9).

The recovery movement has primarily been influenced by western mainstream and highly individualised understandings of mental health. As a result, the underlying concepts of recovery do not necessarily directly transfer to the concepts of wellbeing or mental health for people from Aboriginal and Torres Strait Islander communities. However, there is some synergy with the shift in focus away from a primary emphasis on clinical recovery and some parallels and shared understandings as the following quote suggests:

> We believe that situating mental health within an Aboriginal and Torres Strait Islander SEWB framework is more consistent with the view that Aboriginal and Torres Strait Islander concepts of health and wellbeing prioritise and emphasise wellness, harmony and balance rather than illness and symptom reduction (Dudgeon et al., 2014, p. 64).

In their exploration of the parallels between SEWB and recovery, Nagel et al. state:

> there remain many similarities between recovery concepts and priorities across cultures: service user stories are central to development of shared understanding, tools for goal setting and collaborative care planning are needed, and a focus on relationships, social inclusion and meaningful roles is vital" (2012, p. 221).

Recovery oriented practice with Aboriginal and Torres Strait Islander communities is further discussed later in this report (see section Working with Aboriginal and Torres Strait Islander Communities).

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 consumers. A recovery-oriented approach can be implemented across the spectrum of mental health service settings, from clinical services to psychosocial disability supports, such as the NDIS (Australian Government Department of Health, 2013).

Recovery-oriented practice in the NDIS environment occurs in the context of 'psychosocial support', which has been defined as:

> Address[ing] a person's emotional, social, mental and spiritual needs. Supports include a range of services to help people manage daily activities, rebuild and maintain connections, build social skills and participate in education and employment (Productivity Commission, 2020, p. 25).

Incorporating recovery-oriented practice in psychosocial support in a meaningful way requires an attitudinal adjustment by the worker to see hope and possibility in the lives of individuals who experience psychosocial disability. Further, it asks the worker to trust that the consumer is the best person to decide what they would and would not like in their lives, and to ensure the active undertaking of support tasks that are in line with this approach. To explore 'good practice' in recovery-oriented psychosocial disability support, this section of the report outlines the National Framework for Recovery-Oriented Mental Health Services (the National Framework), the current NDIS environment and Australian models of recovery-oriented practice in the mental health service delivery context.

The Current National Framework

The National Framework for Recovery-Oriented Mental Health Services (the National Framework) defines recovery-oriented practice as:

> Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing, and to define their goals, wishes and aspirations (Australian Government Department of Health, 2013, p. 2).

The National Framework states of recovery-oriented practice that it:

- Promotes a culture and language of hope and optimism: ensures service culture and language that makes a person feel valued, important, welcome, and safe, communicates positive expectations, and promotes hope and optimism;
- Is person first and holistic: putting people who experience mental health issues first and at the centre of practices and delivering services; viewing a person's life situation holistically;
- Supports personal recovery: personally defined and led recovery at the heart of practice rather than an additional task;
- Requires organisational commitment and workforce development: service environments and cultures that are conducive to recovery and a workforce that is appropriately skilled, equipped, supported, and resourced for recovery-oriented practice; and
- Takes action on social inclusion and the social determinants of health, mental health and wellbeing: upholding the human rights of people experiencing mental health issues and challenging stigma and discrimination, and advocating to address the poor and unequal living circumstances that adversely impact on recovery

(Australian Government Department of Health, 2013, p. 2).

The Current NDIS Environment

The National Disability Insurance Scheme (2020), reflecting the National Framework (Australian Government Department of Health, 2013), defines recovery-oriented practice as encapsulating a strengths-based approach, maximising self-determination and self-management, being inclusive of diversity and cultural safety, and working to assist families and community.

The National Disability Insurance Agency (NDIA) has engaged in extensive consultation with peak bodies and consumer groups to improve the delivery of services to better meet the needs of people with psychosocial disability. The NDIA, in consultation with Mental Health Australia (MHA) and other government bodies, has identified priority areas for improvement with respect to psychosocial disability, including the following:

- Improving the NDIS access process;
- Developing better responses to the episodic nature of psychosocial disability; and
- The introduction into the NDIS of evidence-based psychosocial disability supports to improve the social and economic participation of people with psychosocial disability (National Disability Insurance Scheme, 2020, p. 3).

The NDIS Psychosocial Recovery Coach

The NDIS Psychosocial Recovery Coach (recovery coach) is a new support item available to participants with psychosocial disability. The recovery coach's introduction as a new support item is one of the NDIA responses to recommendations on integrating recovery-oriented practice into the Scheme. The NDIS intends recovery coaches to support participants in numerous dimensions of recovery. These dimensions include increased independence, social participation, economic participation, self-control, and management of daily living. A recovery coach seeks to support a participant through developing a recovery-enabling relationship with them. It is achieved by dedicating specific time with the participant, and the people important to them, to develop an understanding of the participant, and their needs and desires. Collaborating with the broader system of supports is also part of the role. The goal of recovery coaches is to support the participant by finding out about different services and supports, and how these may be of assistance. Support in navigating mental health services, as well as better understanding and engaging with the NDIS, are also crucial elements of the role.

The NDIS has acknowledged the value of lived experience and peer support in recovery by offering participants the option to choose a recovery coach with either lived experience or learned experience. All recovery coaches are required to have certain competencies to successfully fulfil their role in supporting participants as follows:

- Demonstrated knowledge and understanding of psychosocial disability and recovery, including trauma informed practice, supported decision-making, and family inclusive practice;
- Ability to facilitate access and coordination of community resources, services, and other government service systems. This includes collaborating with mental health services in planning and coordinating supports to implement the person’s plan and any plan review, and to ensure support responses are coordinated;
- Demonstrated ability to engage with participants to build a trusting, coaching relationship that motivates and builds their capacities to problem solve, review progress, reflect and learn, and provide and elicit feedback;
- Understands the episodic nature of mental health conditions and collaborates with relevant services to plan and maintain engagement through periods of increased support needs; and
- Lived experience recovery coach: Demonstrated ability and willingness to use lived experience of mental ill-health and recovery to provide support and enable recovery

(National Disability Insurance Scheme, 2020, p. 12).

Recommended qualifications for recovery coaches are a Certificate IV in Mental Health Peer Work (for those with lived experience) or a Certificate IV in Mental Health or Community Services or similar training; and two years' experience in a related position (National Disability Insurance Scheme, 2020). Notably, the skillset of lived experience recovery coaches is from their expertise and personal experience of recovery. In contrast, recovery coaches with learned experience will utilise the knowledge gained from their professional training and practice. Recommended resources for recovery-oriented practice for recovery coaches are PULSAR, Collaborative Recovery Model (CRM) and Intentional Peer Support (National Disability Insurance Scheme, 2020, p. 15). Each of these resources will be further described in this report.

Models of Recovery-Oriented Practice

As discussed in the background, there is no one single definition of recovery as it is experienced by the individual. The changing landscape of recovery has influenced recovery-oriented practice through several leading approaches, including but not limited to: lived experience expertise and Intentional Peer Support (n.d.); the REFOCUS (Leamy et al., 2011) and PULSAR models (Meadows et al., 2016b); the WHO Quality Rights Framework (World Health Organisation, 2019); person-centred approaches (NHS Education for Scotland, 2012); trauma informed practice (Greenwald et al., 2008); understanding and responding to the social determinants (Allen et al., 2014); and social and relational recovery (Topor et al., 2011). These approaches to recovery-oriented practice can be conceptualised through their origins and the driving forces behind them representing different theoretical and philosophical perspectives. In Table 1 (see below) these have been outlined.

The *Increasing and Improving Community Mental Health Supports in Western Australia* (Kaleveld et al., 2020) co-designed project encapsulates some of these recovery elements to change policy frameworks in the Western Australian mental health sector. Kaleveld et al. (2020) suggest four recovery domains: personal recovery, relational recovery, social determinants of health and wellbeing, and recovering citizenship. From this recovery model, the following principles of recovery-oriented practice were outlined: safety; flattening power; belonging; welcoming and non-discriminatory; choice and self-determination; social context; engagement; peer developed and led; collaboration; and evaluation (Kaleveld et al., 2020).

Aspirations for Recovery-Oriented Practice

In the *People Making Choices* project (Brophy, Bruxner, et al., 2014), people with psychosocial disability were asked about their goals and aspirations. Many spoke about the importance of a worker who provides good support as an enabler to a good life (see Figure 1). In the project, the participants used the terminology 'good' support person to describe their ideal worker (Brophy, Bruxner, et al., 2014, p. 91).

A 'Good' Support Person: The Key Enabler for a Good Life

FIGURE 1: A 'GOOD' SUPPORT PERSON (BROPHY, BRUXNER, ET AL., 2014).

Hayes et al. (2018) also reviewed research that had asked participants about their perspective on their future priority needs. The following lists the needs (in order of priority) identified by people living with serious mental health conditions or psychosocial disability:

- Uncontrolled symptoms;
- Loneliness/social isolation;
- Financial stress;
- Lack of employment/daytime activities;
- Physical health;
- Suitable housing;
- Need for family or carer support;
- Help to deal with stigma/discrimination;
- Access to mental health services;
- Support in distress; and
- Information
  (Hayes et al., 2018).

Hayes et al. (2018) concluded that people with psychosocial disability, or emerging psychosocial disability, should be able to access early intervention to achieve their social and economic participation goals. They identified taking a recovery-oriented approach, choice and control, and access to evidence-based interventions as three essential elements (Hayes et al., 2018). Subsequent consideration of this model suggests that this support also needs to be culturally safe, respectful of a person's cultural, and spiritual beliefs, to bring together all the essential features of good practice.

Leading Practice Perspectives

Recovery-oriented practice perspectives inform different elements and frameworks of good practice. Each of the models or perspectives listed in Table 1 (see below) is informed by differing discourses on recovery, theoretical understandings, and mental wellbeing perspectives.

TABLE 1: LEADING RECOVERY-ORIENTED PRACTICE PERSPECTIVES.

Recovery-Oriented Practice Model or Perspective	Origin / Group	Leading Discourse/Theory
Intentional Peer Support and lived experience expertise	International - Individuals, carers and families with mental health conditions, and/or experience of service use	• Survivor movement • Recovery is owned by consumers • Promotes lived experience workforce • Focus on empowerment and power-sharing • Emphasises impact of 'trauma causing' services
The Collaborative Recovery Model	AU – Developed and implemented in Australia	• Theories of change and empowerment from positive psychology • Person-centred and strengths-focused coaching • Values clarification and motivation enhancement • Strong evidence base
REFOCUS and PULSAR	UK – Leading framework from the UK, adapted to Australia	• Utilises CHIME model of recovery: connectedness, hope, identity, meaning and purpose, and empowerment • Positive psychology • Recovery-promoting relationships using a coaching framework • Strong evidence base
WHO Quality Rights Framework	International – Collaboration from a large-scale project of stakeholders, academics, and experts Global mental health (psychiatry, psychology, nursing, allied health, lived experience experts)	• Rights focus response to UN Convention on the Rights of Persons with Disabilities (UNCRPD) • Informed by CHIME model of recovery • Incorporates diverse and minority community perspectives • Trauma informed approach • Social model of disability
Person-centred and trauma informed	International – Trauma survivors	• Psychodynamic approach • Critical theory • Survivor movement
Power Threat Meaning Framework	UK – Coproduced (psychology, psychiatry, nursing, allied health, lived experience experts)	• Critical theory • Survivor movement • Centrality of relational, social & cultural factors in shaping distress and trauma • Psychology, narrative • Co-produced approach to thinking about and addressing distress • Conceptual alternative to psychiatric classification and diagnosis

Social determinants of health	International – Public health model	• Understanding of structural conditions and their impacts on individuals (e.g., income, housing, employment, cultural background) • Human rights, inequality, discrimination
Relational and social recovery	International – Carers and families, social work, occupational therapy, and psychology	• Interpersonal relationships, families, and social systems • Social inclusion and community participation • Social capital • WHO International Classification of Functioning, Disability & Health
Choice and control; and personalisation models	International – Emerging from US and UK research and personalisation	• Human rights • Social determinants • Autonomy and control • Supported decision making • Promotion of self-management Promotion of participation and capacity building • Individualised funding models

The Collaborative Recovery Model

The Collaborative Recovery Model (CRM) (Oades et al., 2005) was established to enable evidence-based recovery-oriented practice with people with mental health conditions. Designed for use in the community mental health and psychosocial rehabilitation settings, the model offers an integrative framework of evidence-based modular competencies that is inclusive of lived experience perspectives (Oades et al., 2005).

The guiding principles of CRM are:

- *Recovery as an individual process*. This includes: finding hope, redefining identity, finding meaning in life, taking responsibility, and acknowledging recovery is a personal journey - and that its experience is unique to the individual.

  Collaboration and autonomy support. An effective working alliance supports the recovery process and supports autonomy through a 'self-determination theory approach' of working from the consumer's perspective, providing choice, and acting with transparency (Oades et al., 2005).

The Model's components are:

- Change enhancement;
- Collaborative needs identification;
- Collaborative goal setting and striving; and
- Collaborative task assignment and monitoring (Oades et al., 2005).

Evidence indicates CRM can support the implementation of recovery-oriented policy and knowledge into community mental health practice, and is viewed by consumers and staff as valuable in supporting recovery (Wolstencroft et al., 2018).

REFOCUS AND PULSAR

The connectedness, hope, identity, meaning and purpose, and empowerment (CHIME) recovery framework was developed in the UK as part of the REFOCUS project (Leamy et al., 2011). The CHIME framework has informed the leading evidence base for recovery-oriented practice frameworks in the UK and internationally (Meadows et al., 2019).

FIGURE 2: CHIME MODEL OF PERSONAL RECOVERY (Leamy et al., 2011).

As a part of the REFOCUS project, a qualitative analysis of current recovery-oriented practice guidance literature found that recovery-oriented practice can be conceptualised through four practice domains: promoting citizenship; organisational commitment; supporting personally defined recovery; and working relationship (Le Boutillier et al., 2011).

Le Boutillier et al. (2011) suggests that recovery-oriented practice promotes citizenship through a human rights focus that incorporates social inclusion, meaningful occupation, and seeing people beyond their role as service users. Recovery-oriented practice requires organisational commitment through resource provision, service structure, workforce planning, culture, and values (Le Boutillier et al., 2011). Supporting personally defined recovery includes being person-centred, strengths-based, using holistic approaches, and peer support. Finally, the recovery-oriented practice domain of working relationship fosters the therapeutic relationships with consumers and families, emphasising partnership and hope.

In Australia, Principles Uniting Local Services Assisting Recovery (PULSAR) was established as a large project to provide recovery-oriented practice training in Victoria, Australia (Meadows et al., 2019). Informed by REFOCUS, the PULSAR training focused on how to develop recovery-promoting relationships using three specific working practices and the CHIME framework (Meadows et al., 2016b). PULSAR training was implemented with mental health staff in both community-managed, and clinical services (Meadows et al., 2019).

The *PULSAR manual for recovery-oriented practice* outlines the recovery-promoting relationships, and working practices for clinical and community managed mental health services (or Secondary Care staff) (Meadows et al., 2016b). Additionally, the PULSAR project produced a manual for primary care practitioners (Meadows et al., 2016a). The REFOCUS project manual, from the UK, informed both PULSAR manuals (Bird et al., 2018).

The essence of PULSAR is that, in the context of a recovery-promoting relationship, three specific conversations/behaviours support recovery. These are called 'working practices':

- Working practice 1: Understanding values, treatment, and support preferences;
- Working practice 2: Assessing strengths; and
- Working practice 3: Supporting goal striving
(Meadows et al., 2016b).

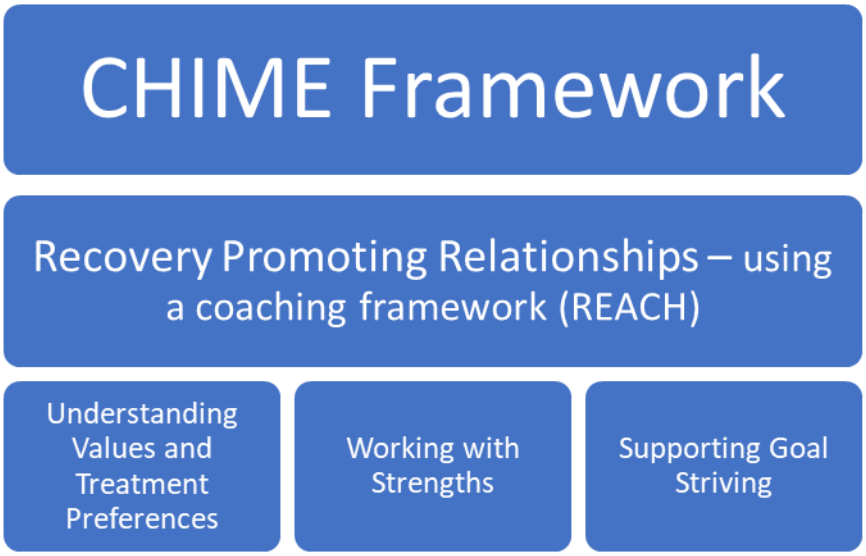


FIGURE 3: ESSENCE OF PULSAR (Meadows et al., 2016b).

The PULSAR study used a randomised control trial design, which provides supportive evidence for recovery-oriented practice training concerning recovery outcomes for consumers (Meadows et al., 2019). This builds on previous evidence from the implementation of CRM in Australia, and REFOCUS in the UK (Meadows et al., 2019).

World Health Organisation Quality Rights Frameworks

Emerging from the United Nations Convention on the Rights of Persons with Disabilities (2006), the *World Health Organisation Quality Rights framework* (WHOQRF) aims to guide the standards for quality of care in mental health services.

The WHOQRF is inclusive of the CHIME framework of recovery (World Health Organisation, 2019). However, it has also sought to address some of the limitations and criticisms of the CHIME framework. The WHOQRF incorporates a human rights approach, promotes the peer workforce, seeks to be inclusive of cultural diversity, focuses on the social determinants of health, promotes empowerment, and includes understandings of trauma (World Health Organisation, 2019). In the WHOQRF recovery-oriented practice model, practitioners and organisations are encouraged to empower consumers by building on strengths to support them in their unique recovery journey (World Health Organisation, 2019).

Recovery-oriented practice in the WHOQRF (World Health Organisation, 2019, p. 14) model starts with the question, "What can we work on together to make your life better?"

This leads to the key tenets of WHOQRF recovery-oriented practice:

- Focusing on strengths and assets;
- Inspiring hope;
- Understanding the values and preferences of the person;
- Working alongside the person;
- Maintaining boundaries;
- Being aware of potential barriers that may hinder the person's recovery journey, including power imbalances within services;
- Supporting the person in positive risk-taking; and
- Connecting the person to the community, including peers and family members (World Health Organisation, 2019, p. 18).

Social and Relational Recovery

People with psychosocial disability are often marginalised and socially excluded (Lloyd et al., 2006). Additionally, they can become isolated and feel disconnected due to diminished connections with family, friends, colleagues, and other community relationships. People may lose previously active roles in the wider community and have limited engagement with a broader range of people beyond those working in mental health roles. There is growing recognition of the crucial role that social factors play in the development of mental health conditions and the recovery journey (Tew et al., 2012). Reconnecting, re-engaging, and repairing relationships and connections with others, including workers, forms part of many people's recovery journey, and is thus an element of recovery-oriented practice. Relational recovery "is a way of conceiving recovery based on the idea that human beings are interdependent creatures; that people's lives and experiences cannot be separated from the social contexts in which they are embedded" (Price-Robertson et al., 2017, p. 2). For Tew et al. (2012), recovery incorporates the idea of being on a journey, of creating a worthwhile and fulfilling life with or without continuing experiences of symptoms Connecting to meaningful activities and communities, as well as establishing connections to people, are all elements of recovery, and a part of recovery-oriented practice. It has been argued that:

> Experiences such as hope, identity, meaningfulness and empowerment emerge at the intersections between people, their relationships and environments; they are best seen as interactional processes rather than states possessed by any one individual (Price-Robertson et al., 2017, p. 5).

Interpersonal Relationships

Worker and Consumer

Topor et al. (2018) argue that recovery occurs through interactional processes in relationships, including the relationship between a worker and consumer. Consequently, workers in everyday encounters and daily practice can make important contributions to peoples' recovery journey, especially in terms of social and relational recovery (Topor et al., 2018).

An effective part of recovery-oriented practice, that also encompasses the understanding that recovery is a social process, are 'small things' or micro-affirmations (Topor et al., 2018). 'Micro-affirmations' is a term coined and defined by Rowe (2008, p. 46) as "apparently small acts, which are often ephemeral and hard-to-see, events that are public and private, often unconscious but very effective, which occur wherever people wish to help others to succeed…are tiny acts of opening doors to opportunity, gestures of inclusion and caring, and graceful acts of listening." This term and others such as 'small things', and 'small acts' are used in the literature to describe the phenomenon (Topor et al., 2018). Common elements of the terms used are the relational aspects, and that, despite being 'small' or 'tiny', they can play an important role (Topor et al., 2018). As Costin (2017, p. 122) states, "these gestures, no matter

how insignificant they might seem, carry infinite weight in a person's sense of wellness and recovery". When characterising what small things are, context is important as they are deemed 'small' in contrast to other 'big things' that occur in everyday life relations and situations (Topor et al., 2018). They are not the big things such as diagnoses or interventions, they are the little things of great importance, that are often taken for granted, which can happen between consumer and worker.

Small things or micro-affirmations can take the form of words, gestures, and actions, affirming a common human ground between the worker, and the consumer (Topor et al., 2018). Small things in the form of words can look like every day small talk and communication that does not solely focus on diagnoses or intervention (Gudde et al., 2013; Topor et al., 2018). Workers sharing experiences from their own lives with consumers, which is often referred to as 'self-disclosure' in a therapeutic setting, can also be considered a small thing (Topor et al., 2018). Workers using simple, welcoming words, as well as being silent together with consumers when appropriate, are other examples of small things that according to consumers are beneficial to the construction of helpful relationships with workers (Topor et al., 2018). These small things as well as the tone used, can convey that a consumers' words are being heard and listened to (Topor et al., 2018). As Topor et al. (2018) highlight, being listened to and heard has both a literal and metaphorical meaning. Gestures are another form of small things and comprise bodily expressions, body language, and physical presence (Topor et al., 2018). It can be highly beneficial for the relationship between the worker and consumer, and consequently the recovery journey to use appropriate eye contact and smiling (Topor et al., 2018). Small things can also be in the form of 'non-gestures' which can include a professional not answering a phone call when interacting with a consumer (Topor et al., 2018). These 'non-gestures' can convey to a consumer that they are the main focus and priority, and full attention is being given to them (Topor et al., 2018). Small things can also be actions. These actions are defined as "more extensive behaviours than gestures, often implying a specific goal and stretched over time" (Topor et al., 2018, p. 1215). A characteristic of these actions that make them 'small things' is that they tend to be normal or ordinary actions done by a professional, but done outside of professional working hours or going beyond the basic requirements of the role (Topor et al., 2018).

Simple actions such as being timely, available, or sharing a coffee and conversation that is not saturated in diagnoses talk can be highly valuable (Topor et al., 2018).
The function of these small things can be the breakdown of the power dynamics that can reinforce the differences between professionals and consumers (Topor et al., 2018). These small things can also remind and reinforce to consumers that they are more than simply a diagnosis or a consumer, and consumers can experience "being like others" (Topor et al., 2018, p. 1216). These simple practices can make important contributions to consumers' recovery journeys, especially in the social and relational domains (Topor et al., 2018; Topor et al., 2011).

Family and Consumer

As well as working to develop and improve relations between worker and consumer there can be a need to support the consumer to improve and re-establish existing relationships with families. The importance of rebuilding or developing family relations is noted as a crucial element of recovery. Consideration and sensitivity should be taken as family relationships can be complex, have varying compositions, informed by the consumer's culture, and preferences. The estrangement may be by choice of the consumer (e.g., family violence) or the family group is chosen rather than by birth. Mental health conditions do not only influence a person but also their families, and other people involved in their support and care (Pernice-Duca, 2010). Price-Robertson et al. (2016) outline six key strategies for promoting relational recovery and practice considerations:

- Understand that recovery occurs in a family context;
- Focus on strengthening parent-child relationships;
- Support families to identify what recovery means for them;
- Acknowledge and build on family strengths, while recognising vulnerabilities;

- Assist family members to better understand, and communicate about, mental health conditions; and
- Link families into their communities and other resources.

Price-Robertson et al. (2016) did not seek to provide a 'how to guide' for workers, but rather a resource that can be used to orient their work and practice to be supportive of family recovery. The importance and benefit of information and education about mental health and mental health conditions for the individual and their families, in addition to family consultation and participation, have been identified as supporting the recovery journey (Pernice-Duca, 2010). A focus on increasing positive and satisfying family contact as well as creating space and opportunities for reciprocity has also been highlighted by Pernice-Duca (2010).

Social Inclusion and Community Participation

As well as working on existing relationships with workers and family, there can be a need for support that enables people to establish new relationships with those in the community (Tew et al., 2012). Social inclusion, a crucial element of recovery, can stem from being a part of social networks, establishing connections, and engaging in meaningful social and occupational activities within the broader community (Tew et al., 2012). Research undertaken by Kaplan et al. (2012) indicates that community participation can facilitate recovery. *The Well Together – A blueprint for community inclusion: fundamental concepts, theoretical frameworks and evidence* by Salzer and Baron (2016) outlined eleven fundamentals of community inclusion. Notably, this report was produced to provide practice principles to guide work that is oriented towards community inclusion and was written with the NDIS aims and goals of providing tailored support in mind.

There are multiple domains where community participation can be promoted and supported to enable a person to develop and maintain social and relational connectedness. As Lloyd et al. (2006, p. 3) argue, it is important "to consider setting specific targets for employment, housing, education or engagement in social activities. The promotion of social inclusion should be incorporated into every service user's care plan". The domains Lloyd et al. (2006) suggest are also reflected in the community participation domains outlined by Salzer and Baron (2016). There is evidence to indicate benefits associated with focusing on these domains for people with psychosocial disability (Salzer & Baron, 2016). Recovery-oriented practice involves supports that addresses a range of domains, such as those listed below, all which impact on the wellbeing and recovery of those individuals with psychosocial disability.

- *Housing*: affordable and sustainable housing is needed to actively address social recovery for people, so they have the opportunity to connect and participate in the community. Recovery-oriented practice addressing factors such as housing has an impact on people's wellbeing, and influences the opportunity for enhanced community participation (Australian Government Department of Health, 2013).
- *Employment*: having employment can positively impact on people's social networks and therefore can contribute to recovery (Webber & Fendt-Newlin, 2017). Interventions such as supported employment have been shown to have the strongest evidence of effectiveness (Webber & Fendt-Newlin, 2017). Webber and Fendt-Newlin (2017) argue that Recovery Colleges are similar in this manner as they provide opportunities for consumers to take up new roles, including as educators and staff (see below education).
- *Education*: Sommer et al. (2018) have suggested that being engaged with peers, such as involvement in Recovery Colleges, can support people in their recovery through regaining social connections. Other social groups that give people access to peer support and others with lived experience can be invaluable as they too can support social interactions. These are opportunities to interact and engage with people with shared experiences. There is the potential for finding role models and inspiration, which can lead to a sense of belonging. These group situations can also be a safe space to learn, develop, and practice social skills.

Getting assistance in developing and rebuilding social skills is a valued support in terms of recovery (Brophy et al., 2015).

- *Spiritual/religious*: being able to participate in activities and exploration of spirituality and religion can be important in terms of connecting with the wider community (Salzer & Baron, 2016). Addressing and providing space for the spiritual and religious needs of people with psychosocial disability can be important for recovery (Fox & Videmsek, 2019).
- *Physical activity/leisure/recreation*: recovery-oriented practice involves support for consumers in identifying interests and activities that can address and enable social inclusion (Salzer & Baron, 2016).

The Lived Experience Workforce[1]

The lived experience workforce, also commonly referred to as the peer workforce, is an emerging professional discipline within the Australian mental health system. In Victoria, peer workers have been employed since 1996 and are increasingly utilised (Victorian Mental Illness Awareness Council, 2019). The lived experience workforce embodies recovery-oriented practice that is grounded in empathy, mutuality, and hope. Lived experience workers act in a professional capacity while drawing on their expertise, knowledge, and training, to engage in roles such as clinical and non-clinical work, support work, peer support, consultancy, care coordination, advocacy, research, education, and management.

The lived experience of mental health challenges and personal recovery is at the centre of recovery-oriented practice, and is the defining feature of peer-based roles. Lived experience professionals are increasingly valued. As Mission Australia (2018, p. 4) states:

> People who have experienced life adversity and have subsequently developed distinctive capabilities required to overcome the difficulties faced, are uniquely placed to provide services to others facing similar life adversities.

Lived experience workers often hold professional qualifications in addition to their own lived experience of mental health conditions and recovery. As a result, lived experience workers have unique learnings, attributes, and capabilities. There is significant evidence to support the impact of lived experience work in facilitating the recovery of consumers. As Davidson et al. (2012) describe, peer support work has been shown to increase consumers' sense of hope, control, and autonomy.

The lived experience work values include mutuality, voluntary engagement, self-determination, hope, responsibility, and empowerment (Western Australian Association for Mental Health, 2014). Lived experience work includes:

- Being values-based and authentically lived experience informed;
- Taking a person-centred, strengths based, and relational approach;
- Enacting recovery principles;
- Conveying, inspiring, and illustrating hope;
- Helping the person navigate access to services;
- Being trauma informed;
- Being responsive and flexible;
- Utilising positive and safe self-disclosure, and shared experience;
- Supporting empowerment; and
- Fostering a culture of "Communication on the base of shared experience and equality" (Schweizer et al., 2018, p. 47).

[1] Note the term 'lived experience work', also known as 'consumer work', 'peer support work', and 'peer work'. The term 'lived experience' is the preferred term by the PRG and the Project.

Lived experience roles included educating other workers, supporting cultural change in organisations, leadership, and improving the recovery-oriented practice of clinicians (Chisholm & Petrakis, 2020).

Schweizer et al. (2018) explored the impact and sustainability of lived experience worker roles and reports that organisational support, including wellbeing, management, and effective human resource strategies was critical. Notably, this is an existing priority area in Australian mental health policy. As the *Fifth National Mental Health and Suicide Prevention Plan* (Australian Government Department of Health, 2017, p. 4) states, [currently] "the peer workforce is sporadically utilised and poorly supported". Another area of development for the lived experience workforce is the support and inclusion of people with lived experience in management roles (Mission Australia, 2018).

Training for the Lived Experience Workforce

Training for peer support workers (i.e., individuals who are providing direct practice support to a person with mental health conditions) typically involves the completion of the Certificate IV in Mental Health Peer Work (Myskills, 2020). This training has been available through the 'Free TAFE for priority courses' initiative in Victoria (State Government of Victoria, 2021), but otherwise can be difficult to access and less affordable.

Intentional Peer Support is another foundational training curriculum which aims to train and support peer support workers through a framework embedded in trauma informed practice, mutuality, connection, and hope (Intentional Peer Support, n.d.). This training has become increasingly favoured by the lived experience workforce (Intentional Peer Support, n.d.).

Other training opportunities can have barriers to access. For example, training opportunities may vary from organisation to organisation. Also, regional peer workers may also have fewer training opportunities than their city-based counterparts. It is important that people in lived experience identified roles also have access to peer networks and peer supervision.

Many of the competencies taught to peer support workers would also benefit people who do not identify as having lived experience, but are open to new ways of supporting people in a mental health setting. This has the potential to enhance recovery-oriented practice through greater sharing of lived experience expertise, but these opportunities are rarely available.

Other Lived Experience contributors

In addition to the Lived Experience workforce, the importance of including a wide range of consumer and carer voices is increasingly seen as a fundamental part of ensuring that the mental health system is recovery oriented. The Productivity Commission's Mental Health Inquiry Report recommends that consumer and carer participation, and advocacy should be embedded in every facet of the Australian mental health system (Productivity Commission, 2020). Further, the Fifth National Mental Health and Suicide Prevention Plan (Australian Government Department of Health, 2017) states that the inclusion of lived experience roles in the mental health workforce has a pivotal role in embedding recovery-oriented approaches and reducing stigma and discrimination. The importance of a lived experience workforce is also recognised by each State and Territory government (Australian Government Department of Health, 2019).

As Byrne et al. (2019, p. 8) states, lived experience workers "use their personal understanding of life-changing mental health challenges, service use and periods of healing/personal recovery, to assist others". The expertise from lived experience may also include experience as a carer, a member of a marginalised community, or from a specific background or experience (Byrne et al., 2019).

People from Aboriginal and Torres Strait Islander communities, Culturally and Linguistically Diverse (CALD) backgrounds, or LGBTIQ+ communities may be included among those with lived experience expertise. Other people may have additional expertise informed by the lived experience of substance use and addiction, trauma and family violence, suicide, eating disorders, incarceration, homelessness, neurodiversity, complex disability, hearing or vision impairment, veterans, older people, or youth (Byrne et al., 2019).

Social Determinants

Housing, transport, education, employment, income security, healthcare are all social, economic, and physical circumstances that come together to form social determinants of mental health. Social determinants influence mental health and recovery as these broad forces shape the conditions in which people live, as well as the services and systems they access (Allen et al., 2014). The *WHO Commission on the Social Determinants of Health* (CSDH) (Commission on Social Determinants of Health, 2008) defines social determinants as:

> The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

The relationship between social determinants and mental health occurs along a gradient in that those with the lowest socioeconomic status typically experience the worst outcomes in terms of mental health (Allen et al., 2014; Fisher & Baum, 2010). Social determinants can shape, to a great extent, mental health conditions as adverse social environments can have a detrimental affect (Allen et al., 2014; Fisher & Baum, 2010). An appreciation and understanding of the social determinants of mental health in turn, contextualises individuals experience of mental health conditions and recovery. However, as argued by Reid et al. (2020, p. 46), there is a tendency to overlook:

> the ways in which social determinants of health intersect with mental illness to produce experiences of oppression and marginalization as well as a lack of knowledge about the lived realities of people with lived experience of mental illness.

Reid et al. (2020)'s study highlights the importance of workers understanding consumers' efforts to manage their mental health in terms of recovery, and the impact the social determinants of mental health have on their recovery journey. Further, as per the *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (United Nations General Assembly Human Rights Council, 2019, p. 1):

> Good mental health and well-being cannot be defined by the absence of a mental health condition, but must be defined instead by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment of their rights and in the equitable pursuit of their potential.

The report also "highlights the importance of the social and underlying determinants of health in advancing the realization of the right to mental health" (United Nations General Assembly Human Rights Council, 2019, p. 2). This report is acknowledged widely in the literature, including in the National Framework, and reflects the increasing acceptance that health, social, economic, and political inequities can adversely affect mental health outcomes (Allen et al., 2014; Fisher & Baum, 2010).

In particular, poverty significantly impacts health outcomes for people with mental health conditions, disabilities, sole parents who are also carers and from marginalised communities (Abidi & Sharma, 2014; Green et al., 2018; Isaacs et al., 2018). It intersects within multiple domains such as social inclusion, employment, secure housing, access to resources and supports, and health and wellbeing. Notably, poverty is associated with elevated levels of psychological distress (Isaacs et al., 2018). Research with people with a disability and their carers from Aboriginal and Torres Strait Islander communities found that social marginalisation, including poverty, homelessness and sole parents caring for multiple children with complex needs, was a particular concern for these families (Green et al., 2018).

Addressing adverse social conditions that can detrimentally affect mental health is necessary to support recovery and a key component of recovery-oriented practice. As outlined in the National Framework (Australian Government Department of Health, 2013, p. 73), recovery-oriented practice should "address poor and unequal living circumstances that adversely impact personal recovery". Recovery-oriented practice that supports social inclusion and advocacy on social determinants requires workers to have a knowledge of social justice issues, human and legal rights, and service systems, in order to challenge

social exclusion and disadvantage, and to advocate for social justice (Australian Government Department of Health, 2013).

When examining the social determinants of health, it is essential to understand how social determinants can intersect, combine and even compound disadvantage. As Cairney et al. (2014) state:

> Intersectionality theory challenges us to consider social determinants not in terms of single factors (eg, gender or SES), but in terms of multiple, interacting factors. In this framework, social disadvantage arises from a constellation of interrelated and intersecting social roles (p. 145).

The intersectional impacts of disadvantage are significant for people from marginalised groups and communities (this is further discussed in Key Population Groups). Intersectionality describes not only the impacts on a person, but the intersecting factors that shape the unique layers of their identity. This is particularly important to understand for people with a disability from Aboriginal and Torres Strait Islander communities, people from Culturally and Linguistically Diverse backgrounds and people from LGBTIQ+ identity groups.

In the National Framework one of the five practice domains is – action on social inclusion and the social determinants of health, mental health, and wellbeing. The capabilities of recovery-oriented practice, which encompasses underlying core principles, values, knowledge, attitudes and behaviours, skills, and abilities, associated with social determinants of mental health outlined in the National Framework include:

- Drawing attention to inequity and contribute to community partnerships to mitigate this;
- Supporting people to understand and act on their human rights, and to self-advocate;
- Actively supporting people's access to naturally occurring community resources, supports, and networks;
- Discussing recovery goals, make appropriate referrals and support access to services and resources that can contribute to:
    - Meaningful social engagement
    - Education, vocational training, and employment opportunities
    - Income security
    - Housing stability
    - General health and wellbeing outcomes
- Helping people and their families to get the most and best out of services—that is, to identify what they want from services, understand when and how to access services, build effective working relationships, make complaints, decide when to exit and so on; and
- Being familiar with the criminal justice system and develop working relationships with police, justice, corrections and probation, and parole
(Australian Government Department of Health, 2013, p. 74).

These capabilities outlined in the National Framework (Australian Government Department of Health, 2013) are particularly important considering, as Malbon et al. (2019) argue, that having the skills to navigate the NDIS can be mediated by a range of social factors. Personalisation schemes such as the NDIS can favour consumers that have good literacy English language, and self-advocacy skills, who have access to social networks that can provide assistance, and who are higher on the social gradient, and therefore not as detrimentally impacted by the intersection with the social determinants of mental health (Malbon et al., 2019). The NDIS and other personalisation schemes have the potential to widen, perpetuate, and entrench existing inequalities linked to the social determinants of mental health (Malbon et al., 2019). This is because those people that are higher on the social gradient can derive more benefit from the NDIS than those individuals with very complex support who are considered lower on the social gradient (Malbon et al., 2019). This happens not just at the point of NDIS access but also at

implementation and in maintaining supports. Market forces and 'choice and control' can enable providers to have the opportunity to choose the individuals they seek to take on as clients and who they do not. As identified in The Centre for Social Impact's submission to the Productivity Commission (Centre for Social Impact, 2017, p. 4) there is:

> Decreased equity if people with lower levels of needs / less complex needs are prioritised by providers because they can be served more efficiently and feasibly

Choice and Control, Personalisation and Recovery

Personalisation models promote individual funding packages or budgets to employ integrated social and health interventions in line with personalised goals (Camoni et al., 2020). These models promote choice and control by providing decentralised welfare that enables individuals and their families to access supports based on their individual needs and goals (Camoni et al., 2020).

As Croft and Parish (2016) explore, personalisation models aim to promote citizenship, independence, and self-sufficiency. In their research, personal recovery or 'existential recovery' is interdependent with other recovery domains, including clinical, functional, physical, and social. The attainment of individualised recovery goals is achieved through the flexible design of the personalised budget, enabling choice and control of spending in each domain (Croft & Parish, 2016). Personalisation has also introduced, or improved, access to early intervention services (Camoni et al., 2020).

Camoni et al. (2020) argue that the personalisation model offers improved choice beyond what to purchase and drives the market to deliver more flexible and competitive service provision, and enhanced continuity of care. Notably, there have been challenges for personalisation models, through privatisation and market-driven services. Some of these challenges have arisen in Australia through market gaps and thin markets, with low service availability, particularly in rural areas (Carey et al., 2018). Research in the UK and US found that personalisation models can have challenges through contesting priorities, such as market competition and increasing complexity whilst ensuring service quality (Croft et al., 2017). As already indicated above, privatised markets can impact equity when services prioritise consumers with a lower level of need or complexity (Centre for Social Impact, 2017). As Carey et al. (2018) advocate, market stewardship by the governing body is required to promote equity and ensure gaps are addressed. "Market stewardship must go beyond ensuring minimum protections and efficient use of resources and extend to ensuring that public good is fairly distributed" (Carey et al., 2018).

In Australia, in the context of the appreciation of the benefits of the shift towards personalisation of service delivery, the Partners in Recovery (PIR) program was introduced to improve service coordination and access to the community for people with severe and persistent mental health conditions (Sutton et al., 2017). PIR featured a support facilitator role, who engaged in care coordination to enable individually tailored care, decentralised control, and funding through a brokerage model (Sutton et al., 2017). A subsequent evaluation reported reduced unmet needs among PIR participants and enhanced recovery over the project's time (Hancock et al., 2018).

Uncovering aspirations and goal setting are central to personalisation models. As Davidson et al. (2017, p. 181) describe:

> A central task of recovery-oriented practice is to elicit and assist the person in envisioning the kind of life he or she wishes to lead, despite or in the presence of an ongoing disability and based on his or her own personal preferences and interests.

The planning process in personalisation approaches is person-centred and focused on self-directed recovery goals, with accountable outcomes which enhance motivation (Croft et al., 2018). An important element of personalisation is coaching by support workers to promote independence through responsibility and accountability of people to their recovery goals (Croft & Parish, 2016).

Notably, the decision-making process must support meaningful choice and control for individuals. This support is significant as many consumers who have experienced institutionalisation, and limited autonomy may require additional supports to help them understand and overcome passive acquiescence, resulting in a form of 'program citizenship' (Davidson et al., 2017). Increased choice in

personalisation models offers improvements in service provision that might also allow for dignity of risk (Camoni et al., 2020). However, the system may need to facilitate informed choice through adequate support to help consumers navigate and understand the services available (Centre for Social Impact, 2017). As the Centre for Social Impact (2017) explores, people may not have access to adequate information to make informed decisions in complex market systems with vulnerable populations. As they state:

> Without a range of services to choose from or sufficient information about what they will receive from each service (outcomes, service quality and approach etc), people can be vulnerable to 'provider- and profession-induced demand' (Centre for Social Impact, 2017, p. 4).

Another central tenet of the personalisation model is the inclusion of lived experience expertise. As Croft et al. (2017, p. 90) states, "people with lived experience must be involved and supported at every level, including direct support, leadership, and oversight". The inclusion of lived experience is also to facilitate communication with stakeholders about the impact of self-direction (Croft et al., 2017).

The engagement of recovery-oriented practice through personalisation models involves individual staff practice, and organisational systems and frameworks. As Croft et al. (2018) identified, the shift to a personalisation model requires organisational supports and culture that promotes self-direction through consumer choice and control. Notably, the principals and values of recovery need to be embedded in the organisational norms and culture, to ensure successful and sustainable implementation (Lorien et al., 2020). As Davidson et al. (2012) explore, an embedded recovery-orientation in organisations is values-driven, at each level of the organisation.

Recovery-Oriented Practice Dimensions in the Context of Personalisation:

- Flexibility and positive risk taking;
- Choice and control;
- Lived experience workforce;
- Personal recovery is interlinked with other domains of recovery such as clinical, functional, physical, and social;
- Need for organisational/systemic support;
- Accountability, promotion of independence, and self-sufficiency; and
- Goal and needs-driven
  (Croft & Parish, 2016; Croft et al., 2017).

Person-Centred and Trauma Informed

Person-centred and trauma informed approaches are instrumental to recovery-oriented practice. This is reflected in the majority of the literature that has informed the practice perspectives in this report. Both approaches involve establishing rapport with the consumer, and ensuring that practice is sensitive and responsive to their individual needs, culture and history. In this section is a brief outline of the person-centred approach in a recovery context, the trauma informed approach, and finally, an outline of the Power Threat Meaning Framework.

Person-Centred

A person-centred approach emphasises the uniqueness and dignity of the individual. The practitioner takes a strengths-based approach that is focused on supporting the pursuit of the person's aspirations and tailored to their circumstances. In Scotland, the *10 essential shared capabilities* resource was developed to improve the person-centred approaches in recovery-oriented practice (NHS Education for Scotland, 2012).

The Recovery Devon Resource Library (2013, p. 5) outlines practices that support recovery, and which exemplify a person-centred approach:

- Active listening;
- Identifying and prioritising personal goals;
- Demonstrating a belief in the person's existing strengths and resources;
- Using shared lived experience narratives to impart hope and validation;
- Implementing Goal setting for living well and meaningful activity;
- Outlining informal supports and resources, including relationships, fulfilling and enjoyable activities, and education, particularly those that further goals and aspirations;
- Encouraging activities that develop resilience;
- Acting with respect and compassion, working in an equal collaborative partnership; and
- Maintaining hope and positive expectations whilst being comfortable with uncertainty and setbacks as a part of the recovery process.

Trauma Informed

Trauma informed practice derives from understandings of trauma from psychology and from neurobiology. Current understandings of trauma explore the physiological, neurological and psychological impacts on the person, and their development. Other understandings of trauma arise from lived experience perspectives, such as the survivor movement in mental health, which emphasise trauma causing practices in institutions.

A trauma informed approach has four key assumptions (Read & Harper, 2020):

- The impact of trauma/s (such as complex, cumulative, and underlying) is pervasive and can impact the person across the lifespan;
- Most people who have received treatment for mental health conditions and substance use have trauma histories;
- Complex trauma frequently arises from childhood abuse and neglect, but not always; and
- Unresolved complex trauma has intergenerational and societal impacts.

Transgenerational trauma refers to the impacts of trauma across generations, including family functioning, attachment, physical and mental illness, and disconnection from culture and society (Menzies, 2019). These effects are intersectional with social determinants of health and can be exacerbated by exposure to continuing high levels of stress and vicarious trauma where children witness the ongoing effects of the trauma which a parent or caregiver has experienced (Menzies, 2019). Transgenerational trauma can have a particular impact on people from Aboriginal and Torres Strait Islander communities. They may have experienced a loss of culture, connection to country and community through colonisation and ongoing impacts of policies such as the stolen generation (The Lowitja Institute, 2018). Underpinning these understandings, it is imperative that cultural safety is a key component to working within a trauma informed approach (Menzies, 2019; The Lowitja Institute, 2018).

Notably, a leading cause of trauma is family violence, which disparately impacts women, particularly those with a disability and people from marginalised communities. For example, the Australian Institute of Health and Welfare (2019, p. 4) reported that "people with disability were 1.8 times as likely to have experienced physical and/or sexual violence from a partner in the previous year, compared with people without disability".

Power Threat Meaning Framework

The Power Threat Meaning Framework (PTMF) was developed in the UK as a coproduced project and explores why people experience mental distress (Johnstone et al., 2018). It is designed as a conceptual alternative to psychiatric classification and diagnosis (Johnstone et al., 2018).

The PTMF upholds a multidimensional view of people and emotional distress, wherein people have agency and influence over their life, while simultaneously facing limitations and barriers to affecting

change. These include external limitations, such as material, biological, psychological, and social barriers. Alongside limitations and barriers that can be created from societal discourse that influence meanings, beliefs, expectations, norms, and values (Johnstone et al., 2018).

A central premise of the framework is that healing is achieved through having experiences witnessed and validated within trusting relationships that are the key to recovery (Johnstone & Boyle, 2018).

Practice values in the PTMF are:

- Non-diagnostic;
- Non-blaming;
- De-mystifying;
- Narratives of strength and survival; and
- Conceptualising survival strategies as helpful and unhelpful (Johnstone et al., 2018).

'Good' Recovery-Oriented Practice

The essential elements from each of the practice perspectives are outlined in Figure 4. This figure has been made with consideration to the literature reviewed in the report.

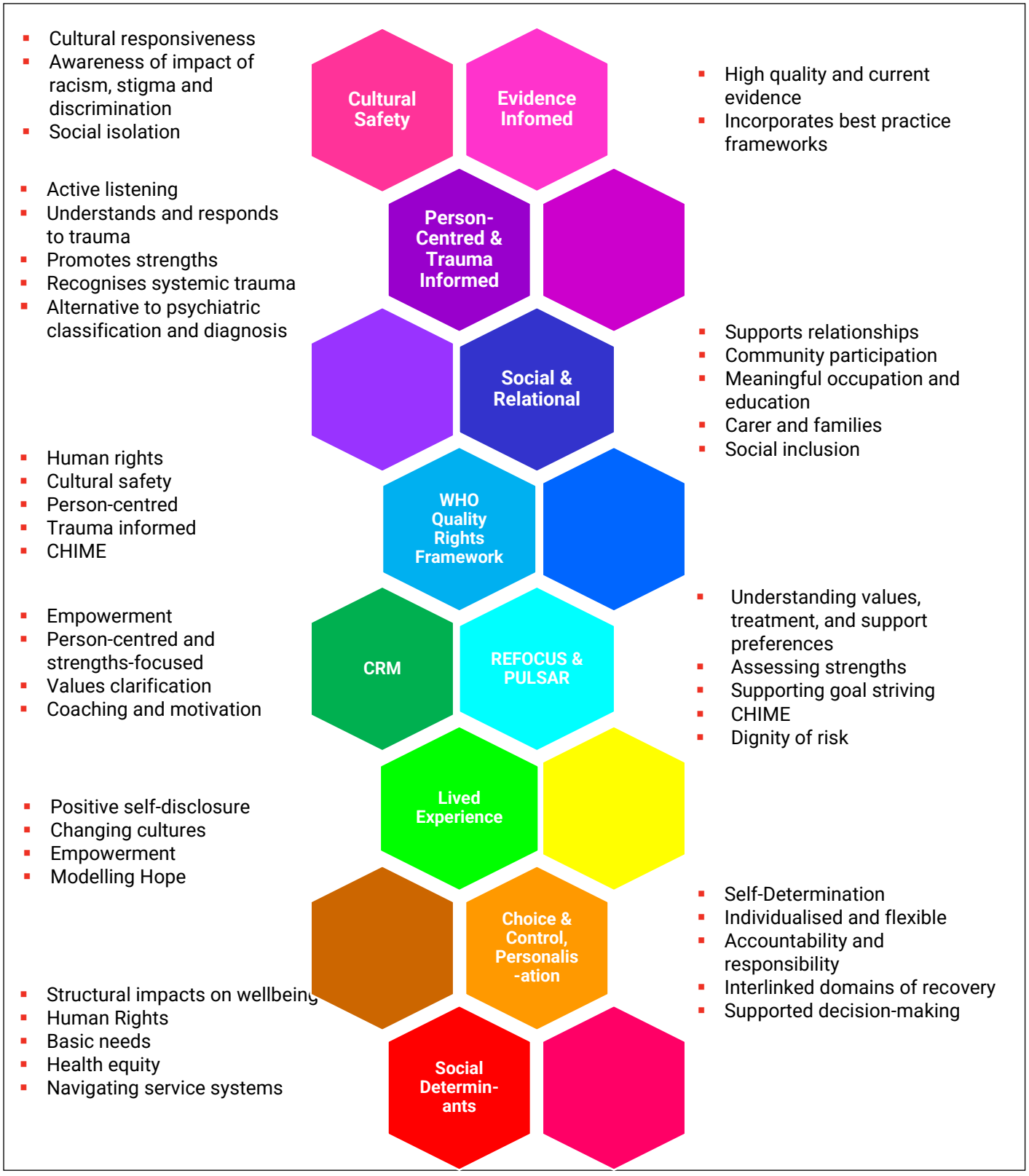


FIGURE 4: 'GOOD' RECOVERY-ORIENTED PRACTICE.

Key Population Groups

The following addresses the question of how recovery relates to NDIS participants with psychosocial support needs:

- From Aboriginal or Torres Strait Islander communities;
- From Culturally and Linguistically Diverse (CALD) backgrounds;
- From LGBTIQ+ identity groups; and/or
- Who have a dual diagnosis, a dual disability, or who have complex support needs.

There is a growing recognition that recovery and recovery-oriented practice needs to be appropriate and applicable to people with psychosocial support needs who are Aboriginal or Torres Strait Islander, from CALD backgrounds, from LGBTIQ+ identity groups, or who are experiencing coexisting conditions, or have complex support needs. Australia is a multicultural nation, home to diverse communities who hold numerous experiences and understandings of psychosocial disability and recovery. Recovery and recovery-oriented practice that considers the needs and support preferences of diverse communities and groups is a priority. Cultural safety is a crucial component of recovery-oriented service delivery. People from these key population groups are not a homogenous group, and can have intersectional experiences of more than one of these identities or categories. It should be acknowledged that there is diversity between and within these groups, and what is appropriate for recovery-oriented practice may vary. Furthermore, as Slade et al. (2014, p. 17) highlights, "assumptions embedded in recovery may be 'monocultural', and broader concepts of community and cultural resilience, and wellbeing may be needed". Focusing on the inner world of individuals and ignoring the complex realities of consumers, their families, identities, and their communities, may see issues related to migration, marginalisation, and racism not being addressed (Price-Robertson et al., 2017).

As outlined in the National Framework (Australian Government Department of Health, 2013) there are some common elements that support diversity in recovery-oriented practice. These common principles and practices include:

- Acknowledging and understanding the importance of relationships in people's recovery journeys;
- Working with families, close relationships, support networks, cultural and social advisers, elders, interpreters, and effectively using other resources that have been developed to support or advise access and delivery of mental health services; and
- Provision of spaces (both physical and emotional) that are safe, supportive and accessible (Australian Government Department of Health, 2013).

Working with Aboriginal and Torres Strait Islander Communities

The National Framework (Australian Government Department of Health, 2013), outlines the importance of mental health workers and providers developing an understanding of the culture and traditions of Aboriginal and Torres Strait Islander people. It is crucial to understand and appreciate the impacts of the continued experiences of intergenerational trauma, racism, dispossession, and marginalisation on Aboriginal and Torres Strait Islander communities (Price-Robertson et al., 2017). Aboriginal and Torres Strait Islander people and communities can have diverse understandings of what constitutes mental health conditions and recovery (Victorian Aboriginal Community Controlled Health Organisation, 2020). Often Aboriginal and Torres Strait Islander communities view health in a holistic manner (Victorian Aboriginal Community Controlled Health Organisation, 2020). The SEWB model, signifies wellbeing which encompasses and illustrates mental health forming part of a multidimensional concept of health (Dudgeon et al., 2014). Dimensions of the SEWB model include the connections to:

- Body;
- Mind and emotions;
- Family and kinship;
- Community;
- Culture;
- Country; and
- Spirit, spirituality, and ancestors
  (Victorian Aboriginal Community Controlled Health Organisation, 2020, p. 24).

These dimensions notably interact, as highlighted in the *Balit Durn Durn: Victorian Aboriginal Community Controlled Health Organisation Inc's Report to the Royal Commission into Victoria's Mental Health System* (2020) report, with social, historical, and political determinants of health and wellbeing. The understanding of holistic healing and the protective factors that support good mental health are represented and explored in depth in the *Balit Durn Durn* (Victorian Aboriginal Community Controlled Health Organisation, 2020).

> Recovery-oriented practice and service delivery with Aboriginal and Torres Strait Islander people must recognise the resilience, strengths and creativity of Aboriginal and Torres Strait Islander people, understand Indigenous cultural perspectives, acknowledge collective experiences of racism and disempowerment, and understand the legacy of colonisation and policies that separated people from their families, culture, language and land (Australian Government Department of Health, 2013, p. 49).

It is also important to acknowledge *The Aboriginal and Torres Strait Islander Engagement Strategy* (National Disability Insurance Agency, 2017) which outlines the NDIA's commitment to deliver the NDIS with Aboriginal and Torres Strait Islander communities across Australia. The recommendations arising from the research provide guidance on how to better engage with Aboriginal and Torres Strait Islander communities, and people with disability. In addition, the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* outlines nine principles which should underpin working with Aboriginal and Torres Strait Islander people and communities (Department of the Prime Minister and Cabinet, 2017).

The National Framework (Australian Government Department of Health, 2013) outlines key elements of recovery-oriented practice responsive to the needs of Aboriginal and Torres Strait Islander people and communities, including but not limited to:

- Ensuring information and communication is in an accessible language;
- Seeking guidance and advice from those with Aboriginal and Torres Strait Islander expertise and Aboriginal and Torres Strait Islander Elders, leaders, mental health practitioners, advisers, and members of the Stolen Generations; and

- Collaborating with families and kinship networks as identified by the consumer, and using technology to support communication where appropriate.

People from Culturally and Linguistically Diverse (CALD) Backgrounds

People from CALD backgrounds are influenced and shaped by the cultural, social, and political circumstances, and experiences of their lives, as are all people. An integral component of recovery-oriented practice is cultural responsiveness and inclusivity (Mental Health in Multicultural Australia, 2014). Awareness of the diversity in cultural beliefs and how these beliefs influence people's understandings of what constitutes mental health conditions and recovery is important (Mental Health in Multicultural Australia, 2014). These beliefs and understandings affect how people explain experiences, display distress, and influence their ability as well as desire to engage with mental health services (Mental Health in Multicultural Australia, 2014). This is articulated in the *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* (Mental Health in Multicultural Australia, 2014, p. 40), "to assist CALD consumers on the recovery journey, mental health services need to understand that recovery and its principles are not universal concepts".

As outlined in both the *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* (Mental Health in Multicultural Australia, 2014) and the National Framework (Australian Government Department of Health, 2013), there are core principles underpinning recovery-oriented practice when working with CALD peoples and communities:

- Recovery is a collection of processes that occur within a web of relations including the individual, family and community and is contextualised by culture, language, oppression and privilege, history, and social determinants of health;
- Responsiveness to people from CALD backgrounds requires organisational capacity at different levels: systemic, organisational and practice; and
- Recognising the diverse ways in which the concepts of mental health, mental health conditions and recovery may be understood by people from CALD backgrounds requires an awareness of the impact of the practitioner's own ethnocultural identity, as well as that of the organisation and service system
  (Australian Government Department of Health, 2013, p. 51; Mental Health in Multicultural Australia, 2014, p. 40).

Recovery-oriented practice that is responsive to the needs of people from CALD backgrounds, as outlined in the National Framework (Australian Government Department of Health, 2013) comprises of several key points:

- Ensure information and communication is in an accessible language for the person, as well as family or support people where appropriate, to enable informed decisions to be made;
- Engage people in the context and involve, where appropriate, families, support people, or other members of their community;
- Work in collaboration with the interpreters, families, communities, workers, and agencies that are important for the person;
- Respect, respond, and demonstrate openness, not only to people's cultural and religious beliefs and faith traditions, but also their perspectives and understandings of mental health, recovery, and how distress and experiences are presented and explained; and
- Consider how trauma, stigma, barriers, as well as misconceptions and/or mistrust of mental health services, and more broadly the government, may play out in interactions.

Lesbian, Gay, Bisexual, Transgender, Intersex, Queer (LGBTIQ+) Identity Groups

As Mink et al. (2014, p. 504) outline, 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." LGBTIQ+ refers to a diverse community of people who may share similar experiences of stigma, discrimination, and self-stigma (Mink et al., 2014; O'Connor et al., 2018). As well as this shared experience, personal experience is influenced by their membership to cultural groups based on their ethnicity, socioeconomic status, geographic location, among a multitude of other characteristics including having a psychosocial disability (Mink et al., 2014; O'Connor et al., 2018). Therefore, LGBTIQ+ people can face unique challenges and situations due to the 'intersectionality' of these experiences (Mink et al., 2014; O'Connor et al., 2018). There have been calls to ensure mental health services address and target the intersectionality and cumulative impact of these experiences (O'Connor et al., 2018). Hence, the relevance of understanding intersectionality:

> Intersectionality is a way of understanding and analysing the complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves
> (Hill Collins & Bilge, 2016, p. 2)

As outlined in the National Framework (Australian Government Department of Health, 2013, p. 55), there are core principles underpinning recovery-oriented practice and skills, behaviours, and knowledge that are important when working with LGBTIQ+ people:

- Demonstrating understanding of and respect for LGBTIQ+ people, as recovery-oriented practice recognises, and affirms diversity in sexuality, sex or gender;
- Appreciation of the negative impact of discrimination, stigma and phobia on the wellbeing of LGBTIQ+ people, and recognition of their vulnerability to subsequently experiencing mental health conditions as a result of these negative impacts;
- Ensuring safe and welcoming spaces and interactions free from discrimination. Physical items such as posters affirming diversity can aid in making spaces welcoming;
- Collaborating and partnering with services and organisations specific to the LGBTIQ+ community;
- Appropriate options and terminology are used, for example on feedback forms, and
- Ensuring cultural competency and training is sought out and embraced by organisations will aid workers to be responsive to the lived experience of LGBTIQ+ people.

People Experiencing Coexisting Conditions and Complex Support Needs

People with psychosocial disability and coexisting conditions and/or complex support needs are a group that have considerable individual variation in experiences. As stated in the National Framework (Australian Government Department of Health, 2013, p. 47), there is a need to "understand the interplay between physical health, mental health, disability and coexisting conditions and the importance of collaboration to address needs simultaneously". Researchers such as Padgett et al. (2016, p. 61) have drawn attention to the significance of 'complex recovery' suggesting that for those people who live with a dual disability or complex support needs, recovery "is the dynamic process of overcoming multiple

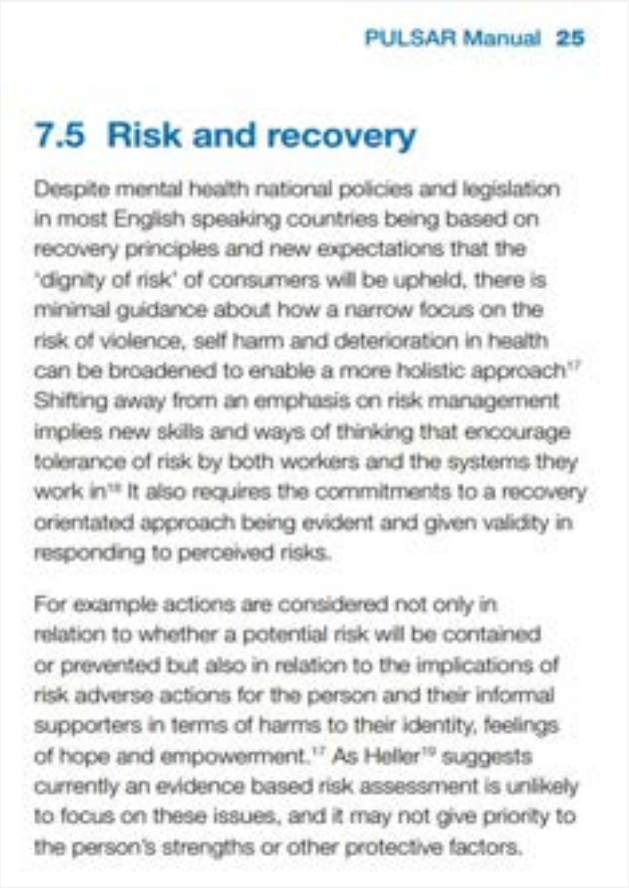
forms of adversity as one pursues a 'recovered life'." The *Allied health capability framework: disability and complex support needs* (Department of Health and Human Services, 2020a) also provides guidance on how person-centred support that promotes choice and control can be provided to people with co-occurring mental health conditions and disability or coexisting health conditions. The Productivity Commission's Mental Health Inquiry Report emphasises the importance of developing person-centred integrated support plans, with the preference for a single plan across services for individuals with complex support needs (Productivity Commission, 2020).

Recovery-oriented practice that is responsive to the needs of people who live with coexisting conditions and complex support needs as specified in the National Framework (Australian Government Department of Health, 2013, p. 48) includes but is not limited to:

- Identify and develop connections with other services and referring agencies;
- Match people's aspirations, expectations, goals, and needs;
- Pursue service responses that match people's aspirations, expectations, goals and needs;
- Demonstrate trauma-informed practice;
- Create opportunities for improvement in physical health, exercise, recreation, nutrition, expressions of spirituality, creative outlets, and stress management; and
- Learn from and be informed by a person's understanding of what helps.

Risk and Recovery

People on Community Treatment Orders (CTOs) are an example of a group of people who may be considered to have complex support needs due to being identified as being at risk of serious deterioration or harm to themselves or others if not on a compulsory order to comply with mental health treatment. In the discussions about recovery-oriented practice, people on CTOs have often been overlooked even though Victoria is one of the highest users of CTOs in the world (Edan et al., 2019). In order to address this gap in the literature regarding providing guidance for supporting people on CTOs in a recovery-oriented way, the PULSAR intervention included the following attention to 'risk and recovery':



PULSAR Manual 25

7.5 Risk and recovery

Despite mental health national policies and legislation in most English speaking countries being based on recovery principles and new expectations that the 'dignity of risk' of consumers will be upheld, there is minimal guidance about how a narrow focus on the risk of violence, self harm and deterioration in health can be broadened to enable a more holistic approach[17] Shifting away from an emphasis on risk management implies new skills and ways of thinking that encourage tolerance of risk by both workers and the systems they work in[18] It also requires the commitments to a recovery orientated approach being evident and given validity in responding to perceived risks.

For example actions are considered not only in relation to whether a potential risk will be contained or prevented but also in relation to the implications of risk adverse actions for the person and their informal supporters in terms of harms to their identity, feelings of hope and empowerment.[17] As Heller[19] suggests currently an evidence based risk assessment is unlikely to focus on these issues, and it may not give priority to the person's strengths or other protective factors.

FIGURE 5: RISK AND RECOVERY (Meadows et al., 2016b, p. 25).

Edan et al. (2019) explored the relevance of recovery-oriented practice to people on CTOs and concluded that utilising recovery-oriented practice principles is possible, but challenging. The following quote from the research highlights the issues:

> As much as I hate to say it, that's kind of what you have to do in a lot of ways, stand up against risk aversion and promote dignity of risk and taking chances and giving people opportunities. I guess it (PULSAR) empowered me to really take that on in a more real way (Edan et al., 2019, p. 181).

In this study, while staff indicated a desire to utilise recovery-oriented practice and saw its relevance to people on CTOs, a lack of organisational support was inhibiting change. Therefore, they concluded that leadership was required for practice change, as well as system transformation.

In the recovery-oriented practice literature, supporting safety is not often discussed. However, it is featured in the NHS' *10 Essential shared capabilities* which include promoting safety and risk enablement (NHS Education for Scotland, 2012). In their research on the impact of values-based training on mental health workers, McGonagle et al. (2015) found that the quality and safety agenda from the *10 Essential shared capabilities* requires careful analysis of staff's role in the multidisciplinary or multi-agency context.

Supported Decision Making

Supported decision-making in recovery-oriented practice is of particular importance for people who are considered to have complex support needs, and people with psychosocial disability. In the *Guidelines for supported decision-making in mental health services* (Brophy et al., 2018, pp. 4-5), supported decision-making is defined as:

> The process whereby individuals are assisted to make decisions through being provided with the support they need. It recognises that the person supported is at the centre of the decision-making process. The process involves individuals receiving support from others to consider, weigh up alternatives and make specific decisions. Supported decision-making may include formal mechanisms such as through advance statements and nominated persons schemes, as well as through informal mechanisms such as help from peers, families, and other supporters.

Care Coordination

Care coordination is a style of service integration which aims to better support people who have complex support needs, including cross sector service needs. Care coordination has been featured in both Australian (Brophy, Hodges, et al., 2014) and international literature (Hannigan et al., 2018; Wiktorowicz et al., 2019) and recognises that health and welfare systems can be difficult to navigate. Although care coordination may not be strongly incorporated in to the NDIS at this time it remains an important service context. The recent Mental Health Inquiry Report by the Productivity Commission (2020, p. 689) made recommendations about care coordination, and concluded that:

> care coordinators needed to be highly skilled and have completed 'vocational qualifications [that] can give care coordinators the skills to navigate the mental health system, and support a culture of collaboration that puts the consumer's needs at its centre' (Productivity Commission, 2020, p. 689).

The Report also concluded that,"While clinical skills may be helpful, perhaps the most important skill required from a care coordinator is the ability to relate to their client" (Productivity Commission, 2020, p. 688). The Productivity Commission's recommended model of care coordination focuses on connecting clinical and non-clinical supports for consumers, and facilitating the navigation between supports. Care coordinators could:

- Help to develop and implement the consumer's care plan;
- Work with the different service providers (including clinical and non-clinical) to ensure the consumer is getting the care they need;
- Work with, involving and helping carers or families (where applicable);
- Help to link the consumer with other services that might be needed but could be outside the care plan;
- For people admitted to hospital, oversee the implementation of a comprehensive discharge plan; and
- Provide advice and guidance to the consumer, their carer or family members (Productivity Commission, 2020, p. 688).

Enablers of Good Practice

This report has begun to indicate some of the important enablers of good recovery-oriented psychosocial disability services and practices. The enablers listed below will be further explored in Stage Two of the literature review and synthesis of good practice report. In the Stage Two report enablers will be considered specifically within the NDIS context, and their relevance considered in relation to psychosocial disability support work.

Recovery-Oriented Services

The shift to an individualised funding package model of service delivery in the transition to the NDIS represents a substantial shift in the way psychosocial supports are delivered (St Vincent`s Mental Health, 2019). The change has created significant opportunities and introduced new challenges for consumers and providers.
Many of the practice enablers require organisational systems, supports and overall culture to ensure that frontline staff can deliver high-quality service provision with a recovery-orientation. As stated in the WHOQRF:

> Recovery-oriented services are not just services where staff have been trained in a recovery approach. The approach involves ensuring that the entire organization of the service is aimed at promoting and facilitating a recovery approach. Recovery is not just a matter of the personal attitudes of service staff. Rather, it needs to be embraced by policies, programmes and the service organization (World Health Organisation, 2019, p. 13).

In the literature, organisational systems are frequently mentioned as a key factor of recovery-oriented practice. For example, these are noted in recovery-oriented practice training and models such as PULSAR (Meadows et al., 2016b), WHOQRF (World Health Organisation, 2019) and CRM (Oades et al., 2005). Notably, this includes leadership and culture within organisations that encourages self-direction, and choice and control by consumers (Croft et al., 2017). In their research into recovery-orientated practice training within mental health organisations, Gee et al. (2017, p. 1775) outline key facilitators for lasting change:

> Lasting change can be facilitated by collaborative action planning, regular collaborative meetings, appointing a change agent, explicit management endorsement and prioritization and modifying organizational structures. Conversely, a challenging organizational climate, or a prevalence of 'change fatigue', may block change. Pre-intervention exploration may help identify any potential barriers to embedding recovery in the organizational culture.

Leading Enablers

Lived Experience Workforce

- Lived experience roles are essential to recovery-oriented practice and should receive adequate support and supervision (Chisholm & Petrakis, 2020).
- A commitment to inclusive hiring practices promotes a diverse workforce that ensures the inclusion of lived experience of mental health and people from key population groups such as Aboriginal and Torres Strait Islander people (Byrne et al., 2019).

Responsive to Trauma

- Sitting at the foundation of recovery-oriented practice is understanding the role and impact of trauma on people with psychosocial disability, and their families and carers (Read & Harper, 2020).
- It is important to note that people with mental health conditions and disability may experience trauma at rates higher than the general population (Johnstone & Boyle, 2018). As

Johnstone et al. (2018) outlined, mental health conditions or disability may also be a result of trauma. Notably, the prevalence of trauma is linked with social determinants of mental health, such as poverty (Johnstone et al., 2018).

- Reflecting the vulnerability of many people with disability, family violence is experienced disproportionately higher by women with a disability, particularly from marginalised groups, including Aboriginal and Torres Strait Islander people (Australian Institute of Health and Welfare, 2019).

Collaborative Service Delivery

- A commitment to collaborative, transparent service coordination with consumers and other service providers, reflects a person-centred approach (Yarra Mental Health Alliance, 2019). Adequate communication with other providers, (with consumer consent) can facilitate the continued pursuit of recovery goals and aspirations, prioritisation of the person's care preferences, and access to preferred providers, where possible (Yarra Mental Health Alliance, 2019).

Sector-Wide Recovery-Oriented Practice Training

- All disability service providers, especially in areas with limited service delivery options and thin markets, should engage with recovery-oriented practice principles (The University of Sydney Policy Lab, 2018). Many people with disability, including those who do not have a psychosocial disability, experience psychological distress or co-occurring mental health conditions (The University of Sydney Policy Lab, 2018).

Transparency and Communication

- Ensuring that communication is prioritised, especially where it impacts quality of care and workers capacity to engage with a recovery-oriented approach. Notably, workers not having access to information about the consumer and their goals is of particular concern (Department of Health and Human Services, 2020b).

Carer and Family Inclusion

- Collaborative care must include carers and families, where appropriate. The inclusion of carers and family members involves adequate communication, and listening (Price-Robertson et al., 2016). Being aware and responsive to carer stress is crucial, with referral networks available where carer stress is identified (KC et al., 2020).

Recovery-Oriented Practice Starts at the Top

- Recovery-oriented practice requires an organisational commitment to promote, educate, support, and recruit staff who engage with recovery-oriented practice principles and values. In the psychosocial disability sector, existing strengths derived from person-centred approaches can be built upon to include other recovery principles in a worker's practice (Davidson et al., 2012; Lorien et al., 2020).

Supporting Staff Through Training and Supervision

- Provide adequate training and supervision.
- Additionally, supervision has a vital role in avoiding stigma. Supervision facilitates workers to address conscious and unconscious beliefs and bias about people who experience mental health conditions (Byrne et al., 2019).

Staff Workload Management

- Quality HR processes are imperative to ensure workers are adequately supported, can voice their concerns, and to avert burnout (KC et al., 2020). This involves careful management of staff workloads and case mixes, and suitable hiring and rostering, to ensure enough staff available who have adequate training.

Ensuring Cultural Safety

- Awareness of the impact of racism, stigma, and discrimination (Productivity Commission, 2020).
- Staff and organisations are mindful and responsive to the cultural needs of their consumers. For example, organisations should provide training in cultural safety and have access to interpreters. Another important factor is that workers understand that many people from diverse backgrounds may have specific cultural and faith traditions, different understandings of mental health conditions (Australian Government Department of Health, 2013).
- Responsive to the needs of Aboriginal and Torres Strait Islander people and communities by providing an environment of cultural safety – promoting shared respect, shared meaning, and shared knowledge, including that of the legacy of colonisation and racism (Australian Government Department of Health, 2013).
- Understanding the impact of intersectionality. Intersectionality is a complex and multidimensional process, involving multiple factors that influence and compound, to create social inequalities (Hill Collins & Bilge, 2016).

Promoting Human Rights

- Fundamental to recovery-oriented practice is recognising the inherent worth, dignity, and rights of all people with disability, including the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (United Nations General Assembly Human Rights Council, 2019).

Understanding Social Determinants

- The social determinants of mental health provide an understanding of the structural impacts on individuals, and who is more likely in our society to experience inequity.
- An understanding that mental health and recovery are influenced by the social, economic, and physical circumstances, as these broad forces shape the conditions in which people live, and the services and systems they access (Allen et al., 2014) is essential.

Interpersonal Skills

- The importance of establishing relationships cannot be underestimated within the support relationship. Further, understanding the complex and important relationships that are a part of consumers' lives is also essential (Topor et al., 2018).

Sector Navigation Skills

- Another recovery-oriented practice element is skills and knowledge in navigating the NDIS service sector, the mental health context and the broader health and welfare system.
- As consumers identified in the People Making Choices report (Brophy, Bruxner, et al., 2014), support workers should be knowledgeable about the mental health system, provide information, undertake referrals and help them navigate the system. In an NDIS context, navigation of both the mental health and disability system is advised. As suggested in the National Framework, support workers “identify and develop connections with other services and referring agencies” (Australian Government Department of Health, 2013, p. 48).

Conclusion

The Current Landscape reports on Stage One of the Literature Review and Synthesis of Good Practice Report for the NDIS ROPDS Project. It has summarised the history of recovery, recovery-oriented practice and the current practice environment. It has also highlighted the enablers of good recovery-oriented practice which may be important for NDIS workers. Stage Two of this project will explore and report on *The Future Horizon,* which will offer broader considerations about how NDIS workers can employ good recovery-oriented practice, how to address the barriers, and workforce-related issues impacting effective recovery-oriented practice for NDIS participants.

References

Abidi, J., & Sharma, D. (2014). Poverty, Disability, and Employment. *Career Development and Transition for Exceptional Individuals*, *37*(1), 60-68. https://doi.org/10.1177/2165143413520180

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

Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial rehabilitation journal*, *16*(4), 11-23. https://doi.org/10.1037/h0095655

Australian Government Department of Health. (2013). *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. (2017). *The fifth national mental health and suicide prevention plan*. http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf

Australian Government Department of Health. (2019). *Peer workforce role in mental health and suicide prevention*. https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools

Australian Institute of Health and Welfare. (2019). *Family, domestic and sexual violence in Australia: Continuing the national story. In brief*. https://www.aihw.gov.au/getmedia/b180312b-27de-4cd9-b43e-16109e52f3d4/aihw-fdv4-FDSV-in-Australia-2019_in-brief.pdf.aspx?inline=true

Bird, V., Leamy, M., Boutillier, C. L., Williams, J., & Slade, M. (2018). *REFOCUS: Promoting recovery in mental health services* (2 ed.). Rethink Mental Illness. https://www.researchintorecovery.com/files/REFOCUS%20Manual%202nd%20edition_4.pdf

Brophy, L., Bruxner, A., Wilson, E., Cocks, N., & Stylianou, M. (2015). How social work can contribute in the shift to personalised, recovery-oriented psycho-social disability support services. *British Journal of Social Work*, *45*(suppl_1), i98-i116. https://doi.org/10.1093/bjsw/bcv094

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

Brophy, L., Hodges, C., Halloran, K., Grigg, M., & Swift, M. (2014). Impact of care coordination on Australia's mental health service delivery system. *Australian Health Review,*, *38*(4), 396-400. https://doi.org/10.1071/AH13181

Brophy, L., McSherry, B., Kokanovic, R., Moeller-Saxone, K., & Herrman, H. (2018). *Guidelines for supported decision-making in mental health Services,* . https://healthtalkaustralia.org/wp-content/uploads/corporate/Guidelines-for-Supported-Decision-Making-in-Mental-Health-Services.pdf

Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., & Darwin, L. (2019). *Queensland framework for the development of the mental health lived experience workforce*. https://www.qmhc.qld.gov.au/documents/qmhclivedexperienceworkforceframeworkwebpdf

Cairney, J., Veldhuizen, S., Vigod, S., Streiner, D. L., Wade, T. J., & Kurdyak, P. (2014). Exploring the social determinants of mental health service use using intersectionality theory and CART analysis. *J Epidemiol Community Health*, *68*(2), 145-150. https://doi.org/10.1136/jech-2013-203120

Camoni, L., Picardi, A., & Venerosi, A. (2020). New mode of care. Value and limit of the person-centered care planning for people with mental disability. *Annali dell'Istituto Superiore di Sanità,*, *56*(2), 193-205. https://doi.org/10.4415/ANN_20_02_09

Carey, G., Malbon, E., Marjolin, A., & Reeders, D. (2018). *National Disability Markets: Market stewardship actions for the NDIS*. Centre for Social Impact. https://apo.org.au/sites/default/files/resource-files/2018-10/apo-nid198046.pdf

Centre for Social Impact. (2017). *Centre for Social Impact Submission to Productivity Commission*. https://www.pc.gov.au/__data/assets/pdf_file/0016/214117/sub448-human-services-reform.pdf

Chisholm, J., & Petrakis, M. (2020). Peer worker perspectives on their potential role in the success of implementing recovery-oriented practice in a clinical mental health setting. *Journal of Evidence-Based Social Work*, *17*(3), 300-316. https://doi.org/10.1080/26408066.2020.1729282

Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. World Health Organization. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

Costin, H. (2017). "You Can Tell when People Like You. You Can't Describe it But You Know It" An Exploration of 'care'. In *Perspectives of Mental Health Clients and Case Managers: Towards a Transformative Education*. McGill University Libraries.

Croft, B., & Parish, S. (2016). Participants' Assessment of the Impact of Behavioral Health Self-Direction on Recovery. *Community Mental Health Journal*, *52*(7), 781-792. https://doi.org/10.1007/s10597-016-9999-0

Croft, B., Simon-Rusinowitz, L., Loughlin, D. M., & Mahoney, K. J. (2018). Mental health leadership perspectives on self-direction. *Social Work in Mental Health*, *16*(4), 381-399. https://doi.org/10.1080/15332985.2017.1395783

Croft, B., Wang, K., Cichocki, B., Weaver, A., & Mahoney, K. (2017). The Emergence of Mental Health Self-Direction: An International Learning Exchange. *Psychiatric Services*, *68*(1), 88-91. https://doi.org/10.1176/appi.ps.201600014

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*, *11*(2), 123-128. https://doi.org/10.1016/j.wpsyc.2012.05.009

Davidson, L., Tondora, J., Pavlo, A. J., & Stanhope, V. (2017). Shared decision making within the context of recovery-oriented care. *Mental Health Review Journal*, *22*(3), 179-190. https://doi.org/10.1108/mhrj-01-2017-0007

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. (2020a). *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 Health and Human Services. (2020b). *Understanding the workforce experience of the NDIS: longitudinal research project*. State of Victoria. https://content.vic.gov.au/sites/default/files/2020-05/NDIS-Longitudinal-Research-Project-Year-2-Report.pdf

Department of the Prime Minister and Cabinet. (2017). *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*. www.health.gov.au/internet/main/publishing.nsf/content/8E8CE65B4FD36C6DCA25722B008342B9/$File/wellbeing.pdf

Dudgeon, P., Milroy, H., & Walker, R. (Eds.). (2014). *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (2 ed.). Commonwealth of Australia,. https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/working-together-aboriginal-and-wellbeing-2014.pdf.

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

Fisher, M., & Baum, F. (2010). The social determinants of mental health: implications for research and health promotion. *Australian & New Zealand Journal of Psychiatry*, *44*(12), 1057-1063. https://doi.org/10.3109/00048674.2010.509311

Fleming, P., McGilloway, S., Hernon, M., Furlong, M., O'Doherty, S., Keogh, F., & Stainton, T. (2019). Individualized funding interventions to improve health and social care outcomes for people with a disability: A mixed‐methods systematic review. *Campbell Systematic Reviews*, *15*(1-2). https://doi.org/10.4073/csr.2019.3

Fox, J., & Videmsek, P. (2019). Exploring the Mental Health and Spiritual Recovery of an Expert-by-Experience: A Discussion of the Unique Contribution Social Workers Can Make to Support This Journey. *Ljetopis Socijalnog Rada*, *26*(2), 235-256. https://doi.org/10.3935/ljsr.v26i2.266

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

Green, A., Abbott, P., Davidson, P. M., Delaney, P., Delaney, J., Patradoon-Ho, P., & Digiacomo, M. (2018). Interacting With Providers: An Intersectional Exploration of the Experiences of Carers of Aboriginal Children With a Disability. *Qualitative Health Research*, *28*(12), 1923-1932. https://doi.org/10.1177/1049732318793416

Greenwald, R., Maguin, E., Smyth, N. J., Greenwald, H., Johnston, K. G., & Weiss, R. L. (2008). Teaching trauma-related insight improves attitudes and behaviors toward challenging clients. *Traumatology*, *14*(2), 1-11. https://doi.org/10.1177/1534765608315635

Gudde, C. B., Olsø, T. M., Antonsen, D. Ø., Rø, M., Eriksen, L., & Vatne, S. (2013). Experiences and preferences of users with major mental disorders regarding helpful care in situations of mental crisis. *Scandinavian journal of public health*, *41*(2), 185-190. https://doi.org/10.1177/1403494812472265

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

Hannigan, B., Simpson, A., Coffey, M., Barlow, S., & Jones, A. (2018). Care coordination as imagined, care coordination as done: Findings from a cross-national mental health systems study. *International Journal of Integrated Care*, *18*(3), 12-12. https://doi.org/10.5334/ijic.3978

Hayes, L., Brophy, L., Harvey, C., Tellez, J. J., Herrman, H., & Killackey, E. (2018). Enabling choice, recovery and participation: evidence-based early intervention support for psychosocial disability in the National Disability Insurance Scheme. *Australasian Psychiatry*, *26*(6), 578-585. https://doi.org/10.1177/1039856218759407

Henwood, B. F., Derejko, K.-S., Couture, J., & Padgett, D. K. (2015). Maslow and mental health recovery: A comparative study of homeless programs for adults with serious mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(2), 220-228. https://doi.org/10.1007/s10488-014-0542-8

Hill Collins, P., & Bilge, S. (2016). *Intersectionality*. Polity Press.

Intentional Peer Support. (n.d.). *What is IPS?* https://www.intentionalpeersupport.org/what-is-ips/?v=6cc98ba2045f

Isaacs, A. N., Enticott, J., Meadows, G., & Inder, B. (2018). Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and Other Policy Areas. *Front Psychiatry*, *9*, 536. https://doi.org/10.3389/fpsyt.2018.00536

Johnstone, L., & Boyle, M. (2018). The Power Threat Meaning Framework: An Alternative Nondiagnostic Conceptual System. *Journal of Humanistic Psychology*, 1 –18. https://doi.org/10.1177/0022167818793289

Johnstone, L., Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The Power Threat Meaning Framework*. British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/PTM%20Framework%20%28January%202018%29_0.pdf

Kaleveld, L., Bock, C., & Seivwright, A. (2020). *Increasing and Improving Community Mental Health Supports in Western Australia*. Western Australian Association for Mental Health. https://waamh.org.au/assets/documents/systemic-advocacy/reports/final-report-increasing-and-improving-community-supports-csi-2020.pdf

Kaplan, K., Salzer, M. S., & Brusilovskiy, E. (2012). Community participation as a predictor of recovery-oriented outcomes among emerging and mature adults with mental illnesses. *Psychiatric Rehabilitation Journal*, *35*(3), 219-229. https://doi.org/10.2975/35.3.2012.219.229

KC, R., Mallyon, A., & Petrakis, M. (2020). Community mental health staff perspectives of the impacts of transition to the National Disability Insurance Scheme (NDIS) on consumers, carers and workforce in Victoria. *Australian Journal of Community Work*, *1*(2019/2020), 1-14. http://www.acwa.org.au/resources/Journal/AJCW-2020-V1-KC-Mallyon-Petrakis.pdf

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services*, *62*(12), 1470-1476. https://doi.org/10.1176/appi.ps.001312011

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445-452. https://doi.org/10.1192/bjp.bp.110.083733

Lloyd, C., Tse, S., & Deane, F. P. (2006). Community participation and social inclusion: How practitioners can make a difference. *Australian e-journal for the Advancement of Mental Health*, *5*(3), 185-194. https://doi.org/10.5172/jamh.5.3.185

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

Malbon, E., Carey, G., & Meltzer, A. (2019). Personalisation schemes in social care: are they growing social and health inequalities? *BMC Public Health*, *19*(1), 805. https://doi.org/10.1186/s12889-019-7168-4

McGonagle, I., Jackson, C. S., & Kane, R. (2015). The Ten Essential Shared Capabilities: reflections on education in values based practice: a qualitative study. *Nurse Education Today*, *35*(2), e24-28. https://doi.org/10.1016/j.nedt.2014.12.001

Mead, S., & Copeland, M. E. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal*, *36*(3), 315-328. https://doi.org/10.1023/a:1001917516869

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. (2016a). *PULSAR Manual: Recovery-promoting relationships and working practices for Primary Care* (2 ed.). Monash University. https://www.monash.edu/__data/assets/pdf_file/0003/1797204/Pulsar-Manual_v3.pdf

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. (2016b). *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 in Multicultural Australia. (2014). *Framework for mental health in multicultural Australia: Towards culturally inclusive service delivery*. https://www.mentalhealthcommission.gov.au/getmedia/59a020c5-ac1e-43d5-b46e-027c44b94654/Framework-for-Mental-Health-in-Multicultural-Australia
Menzies, K. (2019). Understanding the Australian Aboriginal experience of collective, historical and intergenerational trauma. *International Social Work*, *62*(6), 1522-1534. https://doi.org/10.1177/0020872819870585
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
Mission Australia. (2018). *Lived expertise practice framework*. https://www.missionaustralia.com.au/publications/resource-sharing-hub
Myskills. (2020). *Certificate IV in mental health peer work*. https://www.myskills.gov.au/courses/details?Code=CHC43515
Nagel, T., Hinton, R., & Griffin, C. (2012). Yarning about Indigenous mental health: Translation of a recovery paradigm to practice. *Advances in Mental Health*, *10*(3), 216-223. https://doi.org/10.5172/jamh.2012.10.3.216
National Disability Insurance Agency. (2017). *The Aboriginal and Torres Strait Islander Engagement Strategy*. https://www.ndis.gov.au/about-us/strategies/aboriginal-and-torres-strait-islander-strategy
National Disability Insurance Scheme. (2020). *Psychosocial Recovery Coach*. NDIS. https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis#psychosocial-recovery-coach
National Disability Insurance Scheme. (n.d.). *Mental Health Access Snapshot Series: Snapshot 3 – Recovery and the NDIS*. NDIS. https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis#psychosocial-recovery-coach
National Mental Health Consumer & Carer Forum. (2011). *Unravelling Psychosocial Disability, A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions*. https://nmhccf.org.au/sites/default/files/docs/nmhccf_psychosocial_disability_booklet_web_version_27oct11.pdf
NDIS Independent Advisory Council. (2013). *Choice and control: reflections on the implementation of the principle of choice and control under the NDIS*. https://www.ndis.gov.au/html/sites/default/files/documents/council_reflections_on_choice_and_control.pdf
NHS Education for Scotland. (2012). *The Ten Essential Shared Capabilities Supporting person-centred approaches A learning resource for health care staff*. http://www.knowledge.scot.nhs.uk/making-a-difference/resources/ten-essential-shared-capabilities.aspx
O'Connor, L. K., Pleskach, P., & Yanos, P. (2018). The experience of dual stigma and self-stigma among LGBTQ individuals with severe mental illness. *American Journal of Psychiatric Rehabilitation*, *21*(1), 167-187. https://muse.jhu.edu/article/759951
Oades, L., Deane, F., Crowe, T., Gordon Lambert, W., Kavanagh, D., & Lloyd, C. (2005). Collaborative Recovery: An Integrativemodel for Working with Individuals Who Experience Chronic and Recurring Mental Illness. *Australasian Psychiatry*, *13*(3), 279-284. https://doi.org/10.1080/j.1440-1665.2005.02202.x
Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: a review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9. https://doi.org/10.2975/31.1.2007.9.22
Ostrow, L., & Adams, N. (2012). Recovery in the USA: From politics to peer support. *International Review of Psychiatry*, *24*(1), 70-78. https://doi.org/10.3109/09540261.2012.659659
Padgett, D. K., Tiderington, E., Tran Smith, B., Derejko, K.-S., & Henwood, B. F. (2016). Complex recovery: Understanding the lives of formerly homeless adults with complex needs. *Journal of Social Distress and the Homeless*, *25*(2), 60-70. https://doi.org/10.1080/10530789.2016.1173817
Pernice‐Duca, F. (2010). Family network support and mental health recovery. *Journal of Marital and Family Therapy*, *36*(1), 13-27. https://doi.org/10.1111/j.1752-0606.2009.00182.x

Price-Robertson, R., Obradovic, A., & Morgan, B. (2017). Relational recovery: beyond individualism in the recovery approach. *Advances in Mental Health*, *15*(2), 108-120. https://doi.org/10.1080/18387357.2016.1243014

Price-Robertson, R., Olsen, G., Francis, H., Obradovic, A., & Morgan, B. (2016). *Supporting recovery in families affected by parental mental illness Supporting recovery in families affected by parental mental illness*. Australian Institute of Family Studies. https://aifs.gov.au/cfca/publications/supporting-recovery-families-affected-parental-mental-illness

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

Ramon, S., Healy, B., & Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry*, *53*(2), 108-122. https://doi.org/10.1177/0020764006075018

Read, J., & Harper, D. J. (2020). The Power Threat Meaning Framework: Addressing adversity, challenging prejudice and stigma, and transforming services. *Journal of Constructivist Psychology*, 1-14. https://doi.org/10.1080/10720537.2020.1773356

Recovery Devon Resource Library. (2013). *Putting recovery at the heart of all we do: What does this mean in practice? A guide to values, principles, practices and standards*. https://library.recoverydevon.co.uk/items/show/74

Reid, C., Clark, N., Landy, A., & Alonso, M. (2020). The lived experience of recovery: the role of health work in addressing the social determinants of mental health. *Canadian Journal of Community Mental Health*, *38*(4), 45-61. https://doi.org/10.7870/cjcmh-2019-018

Rowe, M. (2008). Micro-affirmations and micro-inequities. *Journal of the International Ombudsman Association*, *1*(1), 45-48. http://marypendergreene.com/wp-content/uploads/2019/12/Rowe-2008-microaffirmations_microinequities.pdf

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

Schweizer, R., Marks, E., & Ramjan, R. (2018). One door mental health lived experience framework. *Mental Health and Social Inclusion*, *22*(1), 46-52. https://doi.org/10.1108/mhsi-10-2017-0040

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

Sommer, J., Gill, K., & Stein-Parbury, J. (2018). Walking side-by-side: Recovery Colleges revolutionising mental health care. *Mental Health and Social Inclusion*, *22*(1), 18-26. https://doi.org/10.1002/wps.20084

St Vincent`s Mental Health. (2019). *St Vincent's Mental Health submission: NDIS participant service guarantee*. https://engage.dss.gov.au/wp-content/uploads/2019/11/St-Vincents-Hospital-Mental-Health-SVHM.pdf

State Government of Victoria. (2021). *Free TAFE for lots of jobs*. https://www.vic.gov.au/free-tafe

State of Victoria Department of Health and Human Services. (2017). *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*. https://www.dhhs.vic.gov.au/sites/default/files/documents/201710/Balit-Murrup-Aboriginal-social-and-emotional-wellbeing-framework-2017-2027.pdf

Sutton, K., Isaacs, A. N., Dalziel, K., & Maybery, D. (2017). Roles and competencies of the Support Facilitator in Australia's recovery-oriented mental health initiative: a qualitative study from Gippsland, Victoria. *Australian Health Review*, *41*(1), 91. https://doi.org/10.1071/ah15183

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. *The British Journal of Social Work*, *42*(3), 443-460. https://doi.org/10.1093/bjsw/bcr076

The Lowitja Institute. (2018). *Journeys to Healing and Strong Wellbeing Final Report, .* The Lowitja Institute. https://www.lowitja.org.au/content/Document/Lowitja-Publishing/lowitja_consulting_journeys_to_healing_report.pdf

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

The University of Sydney Policy Lab. (2018). *Mind the gap: The national disability insurance scheme and psychosocial disability*. https://www.sydney.edu.au/health-sciences/documents/mind-the-gap.pdf

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

Topor, A., Borg, M., Di Girolamo, S., & Davidson, L. (2011). Not just an individual journey: Social aspects of recovery. *International Journal of Social Psychiatry*, *57*(1), 90-99.

United Nations General Assembly Human Rights Council. (2019). *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health - Report of the Special Rapporteur on the right of everyone*

to the enjoyment of the highest attainable standard of physical and mental health. https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/41/34

Victorian Aboriginal Community Controlled Health Organisation. (2020). *Balit Durn Durn: Victorian Aboriginal Community Controlled Health Organisation Inc's report to the Royal Commission into Victoria's Mental Health system*. https://www.vaccho.org.au/assets/01-RESOURCES/TOPIC-AREA/ROYAL-COMMISSION-MENTAL-HEALTH/REPORT/VACCHO-BALIT-DURN-DURN-RCVMH-2020-WEB.pdf

Victorian Mental Illness Awareness Council. (2019). *History of consumer lived experience work in Victoria*. https://www.vmiac.org.au/info/consumer-workforce/

Webber, M., & Fendt-Newlin, M. (2017). A review of social participation interventions for people with mental health problems. *Social Psychiatry and Psychiatric Epidemiology*, *52*(4), 369-380. https://doi.org/10.1007/s00127-017-1372-2

Western Australian Association for Mental Health. (2014). *Peer work strategic framework*. https://waamh.org.au/assets/documents/projects/peer-work-strategic-framework-report-final-october-2014.pdf

Wiktorowicz, M., Abdulle, A., Di Pierdomenico, K., & Boamah, S. A. (2019). Models of Concurrent Disorder Service: Policy, Coordination, and Access to Care. *Frontiers in Psychiatry*, *10*, 61-61. https://doi.org/10.3389/fpsyt.2019.00061

Wolstencroft, K. E., Deane, F. P., Jones, C. L., Zimmermann, A., & Cox, M. (2018). Consumer and staff perspectives of the implementation frequency and value of recovery and wellbeing oriented practices. *International Journal of Mental Health Systems*, *12*(1). https://doi.org/10.1186/s13033-018-0244-9

World Health Organisation. (2019). *Recovery practices for mental health and well-being: WHO Quality Rights specialized training, course guide*. https://www.who.int/publicationsdetail/who-qualityrights-guidance-and-training-tools

Yarra Mental Health Alliance. (2019). *Submission to the Royal Commission into Mental Health July 2019*. https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/6215/7068/6419/Yarra_Mental_Health_Alliance.pdf