Sharing Responsibility for Recovery:

creating and sustaining recovery oriented systems of care for mental health.

Queensland Government
Queensland **Health**
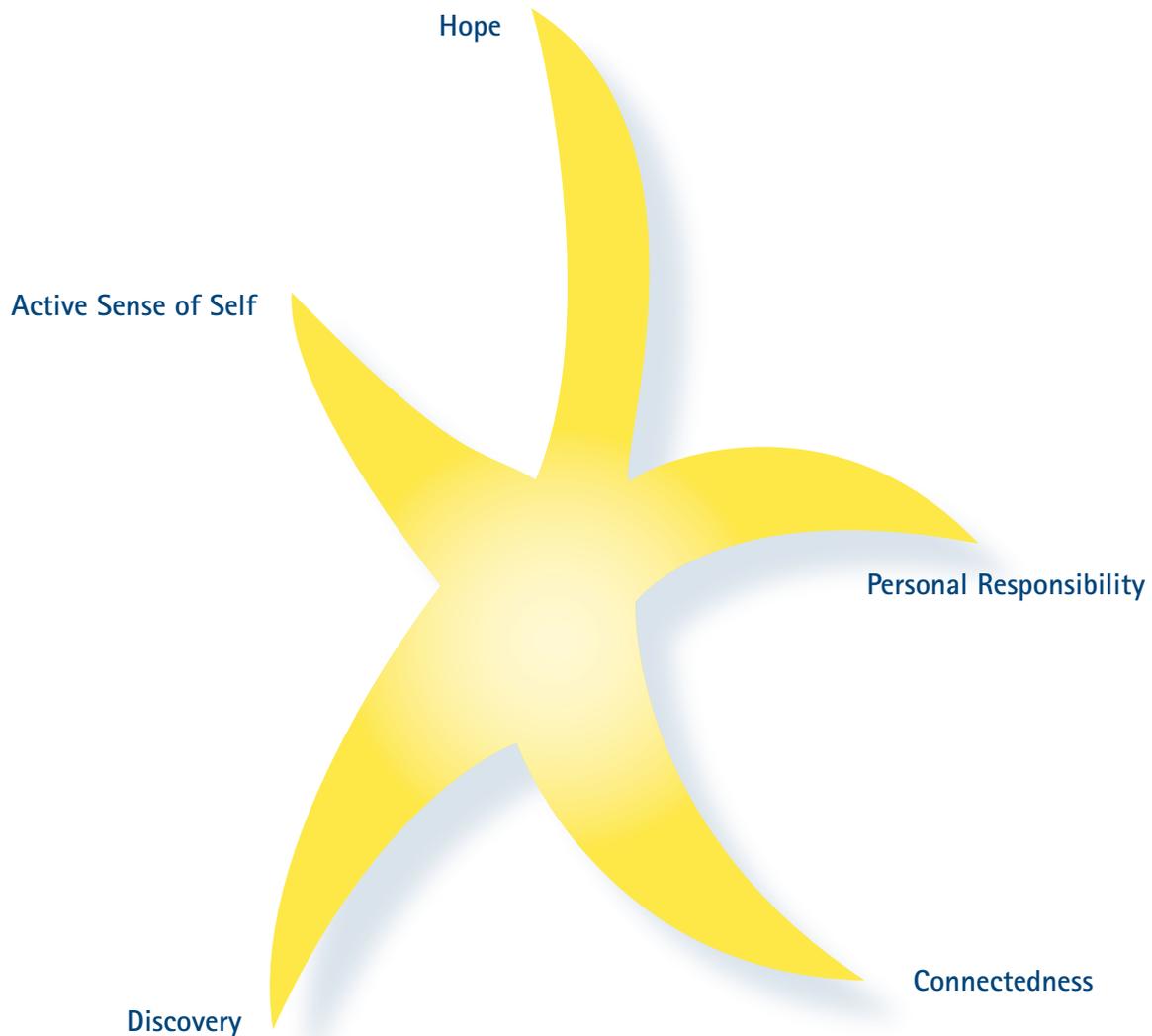
Acknowledgments

Front Cover

The Star Symbol has been designed to reinforce the five common elements identified as necessary in supporting each individual during their recovery journey:

Hope

Active Sense of Self

Personal Responsibility

Connectedness

Discovery

Foreword

This Paper explores the concept of 'recovery-oriented' service provision and provides evidence of strategies that have produced positive outcomes for people with a mental illness in Australia and overseas.

The document is designed to stimulate the inclusion of people with mental illness and their needs into a range of policy and service development processes across government and in the non-government sector.

The paper emphasises the need for a comprehensive system of community based services in which all sectors take responsibility for the mental health of their community so that various services and supports are provided in a coordinated and collaborative manner.

The Recovery approach therefore is consistent with the principles underpinning a range of government Strategic Plans, particularly those that identify 'partnerships' as a major strategic intent. It is also consistent with the *National Mental Health Plan 2003-2008* which was endorsed in 2003 by the Australian, and all States and Territory governments.

The Paper has been developed with the support of an inter-departmental steering committee representing people with mental illness, their families and non-government service providers as well as State and Australian government agencies. The recognition of the importance of an across-government approach has been affirmed by the formal endorsement of the Paper by the Directors-General of the Department of Housing; the Department of Education and Arts; the Department of Corrective Services; the Department of Employment and Training; Disability Services Queensland; the Department of the Premier and Cabinet; the Department of Justice and Attorney-General; the Department of Aboriginal and Torres Strait Islander Policy as well as the Commissioner of the Queensland Police Service.

This document marks an exciting time in the development of service provision to people with a mental illness in Queensland. It also enables the development of a service system that better supports people with a mental illness in our community to live well despite any limitations resulting from the illness, its treatment or personal and environmental conditions.

Dr Steve Buckland
Director General
June 2005

Contents

Executive Summary

The concept of recovery is an emerging paradigm that has significant implications for people with a mental illness, carers, families and service providers. It marks a substantial shift in philosophy from more traditional models of service provision and represents a change in beliefs, services, practices, anticipated outcomes and power relationships.

This document has been developed in response to growing interest by the mental health community in the recovery concept and recovery-oriented systems. The specific aims of this paper are to:

★ develop a shared understanding of recovery and recovery oriented systems,

★ initiate discussion between government departments and key stakeholders on agency responsibilities, and

★ work towards a consistent and coordinated framework of recovery across government and non-government agencies.

Research confirms that even people seriously affected by mental illness can and do recover to live productive lives in their community. However, recovery does not necessarily mean cure, or a return to a pre-illness state. Rather, recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite any limitations resulting from the illness, its treatment, and personal and environmental conditions.

The concept of recovery is embedded in the unique and personal journey of the individual. As a result, it is not possible to identify a definitive formula. Nonetheless, the common elements of each individual's experience do provide some consistent themes. These include:

★ Hope
★ Meaning, purpose and direction
★ Equality and respect
★ Empowerment
★ Social Inclusion and connectedness

These themes underpin the core values that support recovery and guide the implementation of recovery-oriented service provision. As the journey of recovery belongs to the individual, the role of the service provider is to facilitate its process rather than determine its direction. To assist in the promotion of recovery-oriented service provision the following principles have been developed:

★ Services work within a framework of recovery and incorporate philosophies of hope, empowerment and partnership into practice

★ Services encourage and facilitate recovery and wellness throughout every aspect of service delivery

★ Services provide the best help available to everyone and assist people to find the right help at the right time

★ Services understand people in the context of their whole selves, not just their illness

★ Services protect people's rights and treat them with equality and respect

★ Services ensure people set their own goals and measure their own success

★ Services enable people with a mental illness to take on competent roles

★ Services focus on people's strengths rather than concentrating on symptoms and deficits

★ Services are staffed by individuals who are compassionate and competent to assist people in their recovery

★ Services are appropriately utilised by those who require specialist mental health care and discharge occurs in a timely manner

★ Services facilitate and aid natural support networks and look outward to assist people to find and use other more appropriate community services, supports, and resources

(adapted from *Blueprint for Mental Health Services in New Zealand, 1998*)

Recovery emphasises the need for a comprehensive community based service system in which all sectors take responsibility for the mental health of their community and provide services and disability supports in a coordinated and collaborative manner. The importance of developing these partnerships has been highlighted in a range of strategic plans, including the *National Mental Health Plans (1998) (2003), Ten Year Mental Health Strategy (1996), Queensland Mental Health Strategic Plan 2003-2008, Queensland Health Strategic Plan 2004-2010, Queensland Government Strategic Framework for Disability 2000-2005,* the *Strategic Plan for Psychiatric Disability Services and Support 2000-2005, the 5 Year Strategic Plan for People with a Disability 2001-2006 (Housing)* and the *Queensland Department of the Premier and Cabinet Strategic Plan 2002-2006.*

When examining the development of a comprehensive and accessible service response it is important to address all the issues associated with mental illness. As the basis of recovery is the personal experience of each individual, a range of service options need to be considered. These include:

★ Peer Support and Self Help
★ Family Education and Support
★ Mental Health Services
★ Primary Health Care
★ Disability Support
★ Community Infrastructure
★ Housing
★ Vocational Rehabilitation/Employment
★ Drug and Alcohol Services
★ Trauma and Abuse Services

The concept of recovery provides an inspiring new paradigm to inform the future development of services for people with a mental illness, their families and carers. However, the development of a recovery-oriented system is still in its infancy. Much more work needs **to be done to examine the implementation of these principles and to convert the philosophy of recovery into reality.**

Introduction

Internationally, the field of mental health has witnessed a period of extraordinary change. In Australia, the *National Mental Health Strategy (1992)* has marked a decade of unparalleled reform. However, with an aging population, workforce shortages, predicted increases in health care costs and escalating demand for mental health care services, the field of mental health faces considerable challenges for the future (Queensland Health, 2002). Recovery provides a compelling paradigm to consolidate these past achievements and offers a unifying vision to embrace future challenges.

The concept of recovery is not new and has been used by people with a mental illness since the 1980's. Many of the themes articulated in recovery literature are also consistent with contemporary state and national policy. Consequently, there is increasing interest in recovery as an alternate framework to traditional models of care, providing a source of inspiration and hope for people with mental illness, their families, carers and service providers. This is reflected in the growing number of Queensland service providers looking to adopt recovery oriented practice and developing innovative approaches to service delivery.

Recovery acknowledges that having a mental illness does not necessarily mean life long deterioration. This is supported by research which confirms that even people seriously affected by mental illness can and do recover. People with a mental illness are recognised as whole, equal and contributing members of our community, with the same needs and aspirations as anyone else. As a result, when working to facilitate recovery, the basic elements of citizenship such as ability to live independently, form social relationships and access employment opportunities, need to be considered. In doing this it is important that all relevant stakeholders adopt and are supportive of recovery-oriented service provision. To make this shift service providers must have a comprehensive understanding of the recovery concept and incorporate recovery principles into every aspect of practice.

Recovery, as a guiding philosophy, has had most influence in the area of adult mental health. However, the key themes of this paradigm have implications for all levels of service delivery and across the spectrum of ages. Specifically child and youth mental health services, and broader developmental and educational psychological frameworks, emphasise the importance of personal resilience as well as external protective factors to the development and maintenance of mentally healthy and self-determining individuals. These approaches view individual characteristics such as pro-social and relationship skills, problem solving, personal achievement, sense of self efficacy and internal locus of control within a broader ecological or systems framework. Therefore, much of the ideology that underpins recovery such as community processes, strengths focus and connectedness are already an integral part of these services. As a result, while the language of these services may focus on resilience rather than recovery, the practices and experiences of this sector have much to contribute to the implementation of recovery principles.

In the cross-cultural context, recovery involves a journey of respectful curiosity and reciprocity. When exploring the various explanatory models of individuals and systems, the beliefs and views of the individual and family from culturally and linguistically diverse (CALD) communities must be understood and validated. In addition, as many CALD communities are collectivist and based on the interdependency within the family and broader community, it is essential that the family is involved and play a primary role in treatment. As a result, recovery oriented service provision requires an understanding of an individual in their cultural context, including their cultural and ethnic identity, and a willingness to provide flexible services appropriate to the explanatory model of the individual and their family.

The need to understand the cultural context of people affected by mental illness is particularly significant for service providers working with people from Aboriginal and Torres Strait Islander communities. While the concept of recovery can complement Indigenous practices, it is important that service providers recognise the historical context that frames the Indigenous experience. Aboriginal and Torres Strait communities as a whole still struggle to overcome the effect of past government policies that impacted on basic human rights, making the development of a new and valued sense of identity difficult. In addition, as the concept of self-determination has only recently been applied to Indigenous communities, adopting a framework which embraces the value of the individual and self worth can be challenging. Nevertheless, by focusing on strengths and working from a recovery oriented framework, it may be

possible to support people from an Indigenous background to increase their sense of self worth and help facilitate their personal journey. To examine these issues further and to address the concept of recovery from the Indigenous perspective a separate supporting document will be developed.

Purpose of the paper

This Paper has been developed in response to increasing interest in the concept of recovery, and recovery oriented systems as well as the implication these have for people with a mental illness, carers, families and service providers. This paper investigates the recovery concept with a view to:

★ developing a shared understanding of recovery and recovery oriented systems,

★ initiating discussion between government departments and key stakeholders on agency responsibilities, and

★ working towards a consistent and coordinated framework of recovery across government and non-government agencies.

What is recovery

The concept of recovery is a powerful paradigm that has significant implications for people with a mental illness, carers, families and service providers. Recovery is an extremely unique and individual process that is more about the journey than the destination. It is a process that involves an overall upward trend but is not linear or planned. It involves growth and setbacks, and periods of slow and rapid change. It is a process that is often lengthy and complex, and does not necessarily mean symptom elimination or individuals returning to a pre-illness state.

'Recovery is something I experience intermittently. It comes and goes but it always leaves me feeling a little bit stronger and more able to endure the bad times.'
Morzie

Recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite any limitations resulting from the illness, its treatment, and personal and environmental conditions.

Both research and anecdotal evidence support the concept of recovery. Longitudinal studies have concluded that mental illness does not necessarily lead to continued deterioration and that the restoration of complete functioning is possible for most individuals seriously affected by mental illness (Jacobson & Curtis, 2000; Harding et al 2002; Kalyanasundaram, 2002). Harding et al (1992) (Table 1) compared the results of five follow up studies of people with the diagnosis of schizophrenia and concluded that half to two thirds of participants considerably improved or recovered and were found to be functioning as indistinguishable members of their community.

Table 1. Results from five follow up studies of persons with the diagnosis of schizophrenia. (Harding et al 1992)

	Sample size	Average length in years	% Subjects recovered and/or Improved significantly
Bleuler Burgholzi, Zurich	208	23	53 – 68%
Huber et al Bonn studies	502	22	57%
Ciompi & Muller Lausanne Investigations	289	37	53%
Tsuang et al Iowa 500	186	35	46%
Harding et al Vermont	118	32	62 – 68%

There has also been an increasing number of people documenting their personal stories of recovery from mental illness, providing compelling anecdotal evidence of recovery and the various methods of healing (Deegan, 1996; O'Hagan, 1999; Mental Health Commission of New Zealand Recovery Series, 2000).

However, as recovery is a deeply personal journey it is not possible to identify a definite formula. This has led to considerable confusion for those expected to recover and for the services expected to help in this process (Jacobson & Greenley, 2001). All the same, while it is not possible to develop a recipe for recovery, it is possible to identify some consistent themes. These themes are interrelated components shaped by personal, social and physical environments. Consequently, recovery is best understood as a complex interplay between the characteristics of the individual (the whole person, hope, sense of meaning or purpose), the environment (basic elements of citizenship, social relationships, meaningful activities, peer support, formal services and staff), and the exchange (hope, choice, empowerment, independence, interdependence) (Onken et al, 2002).

Hope is the foundation of recovery.

Hope is the limitless belief that things do not have to remain the same and that change can and does happen. It is about concentrating on strengths rather than weaknesses, focussing on the future rather than the past and celebrating small successes rather than insisting on rapid change. Hope fuels the recovery process through expanding the sphere of possibility, colouring life perceptions, and sustaining individuals even during periods of relapse. According to Jacobson & Curtis (2001) hope lays the groundwork for the process of healing to begin.

Unfortunately, for many people with a mental illness, negative stereotypes and destructive predictions for the future result in a loss of hope. This loss leads to a belief that nothing can be done to make the situation better and all efforts to change are futile. This has a damaging impact on identity and self worth, making personal growth, risk taking and recovery impossible. This frequently leads to a situation where individuals allow others, such as service and treatment staff, to make major decisions and set goals on their behalf (O'Hagan,1999). Obviously, without the full and equal input from the individual affected by mental illness these goals are unlikely to be relevant and add to the loss of hope and power. To counter this it is vital that service systems are entrenched in a spirit of hope, and value input and social inclusion. Deegan (1996) stresses that it is imperative that service providers role model hope by continually offering choices, even if they are repeatedly rejected.

> *'Staying positive and being with positive people assist the recovery process. Having positive messages around the home can be reassuring. I have a poster in my bedroom that says 'I am happy, healthy and prosperous now'.'*
> *Anonymous*

Hope can also be generated through the positive life stories of others that have experienced a mental illness. For many, witnessing peers living fulfilled lives in the community is one of the most compelling demonstrations of hope (O'Hagan, 1999).

The literature also makes frequent reference to the importance of people who believe in or stand by the person through their recovery process. These people do not need to be professionals. They may be family, friends or peers. The unifying factor is that it is someone who can be trusted to be there during times of need. The impact the hope of others can have on an individual who has given up cannot be underestimated.

> *'I want to suggest that families, friends, other psychiatric services, professionals and service systems join together as partners and build a community of hope which surrounds the one that may have lost all hope. In this way environments leave good soil in which persons with psychiatric disabilities can take root and begin to grow in their recovery process.' (Deegan, 1991)*

> *'Having just one person believe in you and trust in you is the beginning of the healing process and the road to recovery.'*
> *Anonymous*

Recovery involves finding meaning, purpose and direction for one's own life experience.

For people with a mental illness the sense of self is often lost and identity is assumed around the mental illness. An important part of recovery is reorientating the sense of self apart from the illness and understanding that the mental illness is only one element of the whole person. It is through this process that a more adaptive and positive self-image is created (Young & Ensing, 1999).

Recovery goes beyond self-care and functioning. It is also the development of a more meaningful existence, and sense of purpose. This sense of purpose may be developed through work, relationships, political action or spirituality.

Spirituality, in particular, has been identified as a source of hope, solace, peace and social support. *'There is very much a spiritual element in what happened to me. I maintain that to this day. The psychiatrists don't like me saying it but I keep saying'* (Mental Health Commission of New Zealand Recovery Series, 2000).

In a study by Young and Ensing (1999) it was noted that almost all participants identified spirituality as an essential component of their recovery and a main source of hope and inspiration. This is supported by Onken et al (2002) who acknowledged spirituality as an important source of meaning that is often discounted or ignored by service providers. *'Spiritual fellowship....can promote a sense of hope, healing, community and connection to a source of hope, healing or power beyond oneself'* (Onken et al 2002).

> *'Having a pet to look after is often my reason for getting out of bed and going to the shops to get the food.'*
> *Anonymous*

> *'Before GOD came into my life, the memories of my childhood and the death of my boyfriend were unbearable. This haunted me deeply, I felt great pain and hurt. The depression over took my entire life....I thank GOD for his great love and care in time of my needs. I am pleased and happy how things are progressing in my life.'*
> *Taita*

Recovery is promoted when people with a mental illness are treated with equality and respect.

Regrettably individuals with a mental illness still face substantial stigma and discrimination. They are often the subjects of ridicule, harassment and abuse and have to contend with the negative portrayal of people with a mental illness in the mass media. Apart from the external affects of stigma it is also common for individuals to accept and internalise these negative stereotypes. This can result in considerable barriers to recovery through eroding opportunities, reducing community inclusion and diminishing self-confidence (Mental Health Commission of New Zealand,1998). It is for these reasons that discrimination must be challenged and a system that treats people with a mental illness as equal and valued members of our community be promoted.

The recovery process is enhanced when service providers adopt a positive practice culture. This culture is founded on an indisputable belief that recovery is possible and incorporates concepts of tolerance, listening, empathy, compassion, respect, safety, trust, diversity and cultural competence. This enables workers to shift their focus from the illness to the person and concentrate on strengths rather than weaknesses (Jacobson & Greenley, 2001). By service providers treating all people with respect and dignity it will not only improve outcomes for those accessing services but it will also role model collaborative and positive relationships and may assist in correcting discrimination in the wider community (Mental Health Commission of New Zealand, 1998).

> *'Talking about me and not to me perpetuates the anguish and hinders recovery.'*
> *Anonymous*

Recovery occurs when people are empowered to take ownership and play an active role in their own recovery process.

Individuals affected by mental illness hold the key to their recovery. It is not a process that can take place through the passive receipt of services and it does not need to be facilitated by professionals. What is important is that people with a mental illness are recognised as whole, self-determining persons, able to make choices, take responsibility, live with consequences and exert control over their own recovery process. Deegan states that *'...people must be active and courageous participants in their own rehabilitation project or that project will fail. It is through the process of recovery that disabled persons become active in their own rehabilitation project'* (Deegan, 1988).

When working from a recovery framework it is important that service providers guarantee full participation through individuals setting their own goals and not measuring success by predetermined rules of *'normal'*. People affected by mental illness need to be given the respect to make choices that are relevant to them and afforded the opportunity to fail and learn from mistakes.

The importance of people participating in their own health care has long been recognised as an essential element of effective service provision.
This right is incorporated into the World Health Organisation's *Declaration of Alma Ata (1978)* which states that *'people have the right and duty to participate individually and collectively in the planning and implementation of their health care'*. The key themes of empowerment and participation are also consistent with the principles set out in the *National Standards for Mental Health Services* and the *Disability Services Standards*. In addition, the *Second National Mental Health Plan: 1998-2003* and *Ten Year Mental Health Strategy for Queensland (1996)*, both emphasise the use of service provision that focuses on the needs of the individual.

As stated by Jacobson & Greenley (2001), empowerment is vital for correcting the learned helplessness that many people experience as a result of long-term interactions with the mental health system. The literature emphasises the need for people to develop self-confidence, patience, autonomy, responsibility, determination and a willingness to take risks. Young & Ensing (1999) affirm self-empowerment and the development of proactive coping strategies as significant steps towards recovery. In a study by Corrigan et al (1999) it was found that individuals who presented as 'more recovered' also showed good self-esteem, high self-orientation to empowerment and good quality of life.

The participation of people with a mental illness in the planning, delivery and evaluation of services goes beyond providing the opportunity to participate. People must also be afforded the information and skills necessary to make their interaction with service providers genuine, relevant and effective. It accentuates the need for collaborative relationships between individuals affected by mental illness and service providers, allowing for joint planning, negotiation and decision-making. Service providers need to recognise that the personal knowledge and expertise of individuals with a mental illness and their carers is equal but different from their own knowledge base. The Knowledge Resource Base (Figure 1) emphasises the importance of combining the various types of knowledge to create an enhanced understanding of mental illness.

'Most people would cringe at some of the situations I would get myself into. But for me that would just open up another 'Quest' '.
Allyn

'I was aware of my fragilities and focused on my strengths. I set small goals and took small steps and built up from there. This may sound a bit vain but I realised any achievements I made no matter how small I would pat myself on the back and not wait for feedback from others. I knew what strength I had. How could I expect others to know?'
Anonymous

Figure 1: The Knowledge Resource Base (Trainor, Pomeroy & Pape, 1993)

KNOWLEDGE RESOURCE BASE
types of knowledge that contribute to our understanding of mental illness

| medical/clinical | social science | experiential | customary/ traditional |

A balanced understanding of mental illness
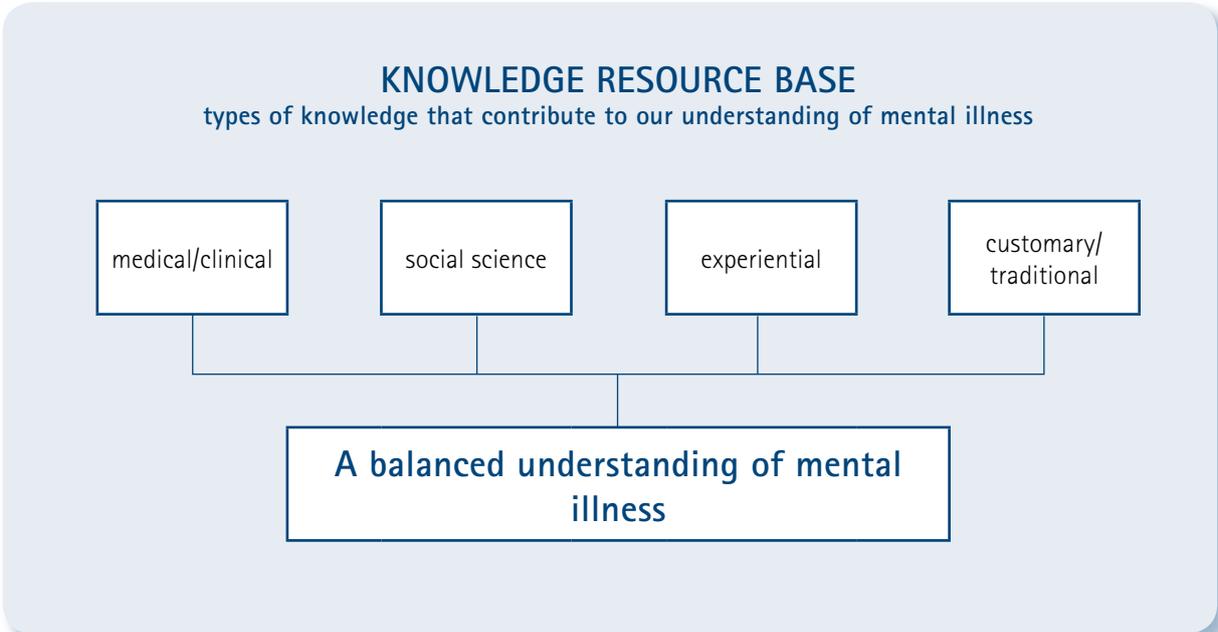
By doing this individuals can be empowered to make choices that may differ from those of the service provider and be given the respect and self efficacy to take responsibility for those choices and in turn their own recovery (Mental Health Commission of New Zealand, 1998).

Social inclusion and connectedness are important components of the recovery process.

Recovery is an extremely social process that involves being with others and reconnecting with the world. To make social connections, social roles must be established. These may be through activities, relationships or occupation.

Several studies have established that people with a psychiatric disability have social networks roughly half the size of the general population and these networks are more likely to contain family members and be less reciprocal in nature. Additionally, limited social supports have been found to increase the likelihood of symptoms and reduce the likelihood of existing supports being accessed during times of stress. As concluded by Leavy, 'the absence of social supports is associated with increased psychological distress' (Wilson, Flanagan & Rynders, 1999).

'My life was not the best, but I tried my hardest to be like others. I could not talk about my problems and kept them within myself. Though I still suffer from depression, I continue attending a creative writing group and pottery classes. I am regaining my confidence, with the support and encouragement from these wonderful people whom I meet at these workshops.'
Taita

In a study by Corrigan et al (1999) it was found that recovery correlated with the size of the people's social support network. While, it is unclear whether greater support leads to an impression of recovery or recovery leads to situations of greater interpersonal support, this study does establish the importance of interpersonal relationships in the recovery process.

For many, relating with peers is an extremely valuable form of connection. These relationships may be created through peer delivered services, advocacy or the sharing of personal stories of recovery. Research indicates that both having peer role-models and acting as peer-role-models are extremely beneficial to the recovery process (Young & Ensing, 1999; Anthony & Blanch,1987). It is through these relationships that many individuals are able to validate and resolve their own experiences.

In fostering social connectedness, issues relating to community integration and full community participation also need to be addressed. The notion of community integration is drawn from the larger disability and civil rights movement and is founded on a belief that all people have a right to full community participation and membership. However, this goal cannot be reached solely through professional services but also through peer support, self-help services and integration into mainstream community activities such as housing, jobs and relationships with non-disabled peers (Carling, 1995).

Recovery-Oriented Service Provision

The consistent themes articulated through the experiences of recovery underpin the core values that support recovery and guide the implementation of recovery-oriented service provision.

Table 2.   Values that Support Recovering (Spaniol, 2001)

Value	Description
Empowerment	Creating a personal vision and having the confidence to move toward it. Feeling *"I can"* versus *"I can't"*.
Personal choice	People know how to lead their life better than someone else does.
Personal involvement	Participating in the processes by which decisions are made that affect one's life.
Community focus	Building on existing resources in the community.
Focus on strengths	Building on existing strengths in the person.
Connectedness	Enhancing relationship to self, others, environments, meaning/purpose.

Recovery is not a service that is 'graduated to'. It is a personal journey that belongs to the individual. The role of service providers is to assist the recovery process, but not dictate its direction. *'For the professional, the recovery approach implies a fundamental shift from "doing for" to "doing with"'* (Carling et al, 1999). Through this, service providers work in a manner that stimulates wellness and focuses on strengths rather than concentrating on symptoms and deficits.

'Talking about me and not to me perpetuates the anguish and hinders recovery.'
Anonymous

To facilitate the promotion of recovery-oriented service provision a set of underlying principles have been developed.

★ Services work within a framework of recovery and incorporate philosophies of hope, empowerment and partnership into practice

★ Services encourage and facilitate recovery and wellness throughout every aspect of service delivery

★ Services provide the best help available to everyone and assist people to find the right help at the right time

★ Services understand people in the context of their whole selves, not just their illness

★ Services protect people's rights and treat them with equality and respect

★ Services ensure people set their own goals and measure their own success

★ Services enable people with a mental illness to take on competent roles

★ Services focus on people's strengths rather than concentrating symptoms and deficits

★ Services are staffed by individuals who are compassionate and competent to assist people in their recovery

★ Services are appropriately utilised by those who require specialist mental health care and discharge occurs expediently

★ Services facilitate and aid natural support networks and look outward to assist people to find and use other more appropriate community services, supports, and resources

(adapted from Blueprint for Mental Health Services in New Zealand, 1998)

Ethical issues

An essential factor of the recovery paradigm is the autonomous role of individuals with a mental illness as valued and responsible citizens, capable of setting goals and shaping their own future. The importance of this is substantiated by evidence identifying the perception of personal control as critical to health and wellbeing (Valimaki et al., 1998; Olofsson et al., 2001). This signifies an important shift from traditional notions of people with a mental illness being incapable of making decisions. Nevertheless, with this shift also comes considerable ethical issues regarding privacy, confidentiality, coercion through involuntary hospitalisation and treatment, and conflictual values (Rudnick, 2002; Szmukler, 1999).

When working from a recovery framework a balance must be struck between affirming the rights of individuals and ensuring decisions are arrived at competently and do not involve serious risk. In doing this it is vital that interventions do not degrade individual self-respect or be seen as a punishment. Recovery and the therapeutic relationship must not be endangered by unnecessary in-patient supervision and coercive models of care (Szmukler, 1999).

'One of the greatest fears for me was loosing self-control but above all my independence. One of the most difficult and challenging tasks was to take back control of my life. I realised very early in my recovery that it wasn't my illness that was causing lots of anxieties it was all part and parcel of the recovery process and transition of walking into the future. Sadly many people don't acknowledge that the realities of recovering from a serious illness or long term hospitalisation causes a lot of anxious moments.'

Anonymous

In examining these issues the standard ethical principles of health care may be applied. These include autonomy and upholding self-determination, beneficence or acting in the best interest of the individual, and justice (Rudnick, 2002). In instances where a person with a mental illness is considered at risk to themselves or someone else it may be necessary for involuntary treatment to be considered. Such a treatment order can only be made if an authorised doctor is satisfied that all the criteria, as stated in the *Mental Health Act 2000*, apply (Mental Health Act 2000). Nevertheless, being on an involuntary treatment order does not mean all opportunities for self-determination are removed.

As part of recovery-oriented service provision it is essential that a dialogue based on mutual respect and constructive discussion between the person affected by mental illness and the mental health professional is established and maintained at all times. Through this process individuals and service providers are able to reflect on decisions and underlying values. In addition, this dialogue may assist people with a mental illness to improve their decision-making processes, set goals, formulate plans for preferred treatment, and develop an agreement at which point future involuntary intervention may be appropriate (Rudnick, 2002; Szmukler, 1999).

'Following encouragement from my Consultant as an outpatient, I created a process for myself whereby after only 2 or 3 weeks of diligent effort and commitment, sometimes painful, my health began to improve noticeably. This healing process, as I saw it, was not only effective on myself, but it also allowed my family life to blossom like never before.'

Ron

The difference between rehabilitation and recovery

Psychiatric and psychosocial rehabilitation involve targeted interventions which aid individuals to acquire and apply the skills, supports, and resources required to live a fulfilled life in their chosen community with minimal ongoing professional intervention. The aim of rehabilitation is the restoration of function and minimisation of psychiatric disability through the development of strengths, restoration of hope, environmental modifications, enhancement of vocational potential and maximisation of social and recreational networks (Munich & Lang, 1993; Curtis, 1997). As stated by Liberman et al (2001) *'The overarching goal of psychiatric rehabilitation is to promote the highest possible levels of social and vocational functioning and well-being for individuals with severe and persistent mental disorders' (Liberman et al 2001).*

Over recent years considerable confusion has emerged regarding the distinction between recovery and rehabilitation. Perhaps the difference between these two concepts is best articulated by Deegan who states 'Rehabilitation refers to the services and technologies that are made available to disabled persons so that they may learn to adapt to their world. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability' (Deegan 1988).

Recovery then forms the basis upon which rehabilitation services can be developed. It provides a framework that goes beyond offering people somewhere to go during the day. A framework of recovery ensures that hope, respect and pathways to community participation are incorporated into the day to day activities of rehabilitation programs (SANE Australia, 2001). However, rehabilitation services should not be considered the only vehicle for recovery. Instead rehabilitation services are one component of a comprehensive service system that collectively works towards the goal of recovery.
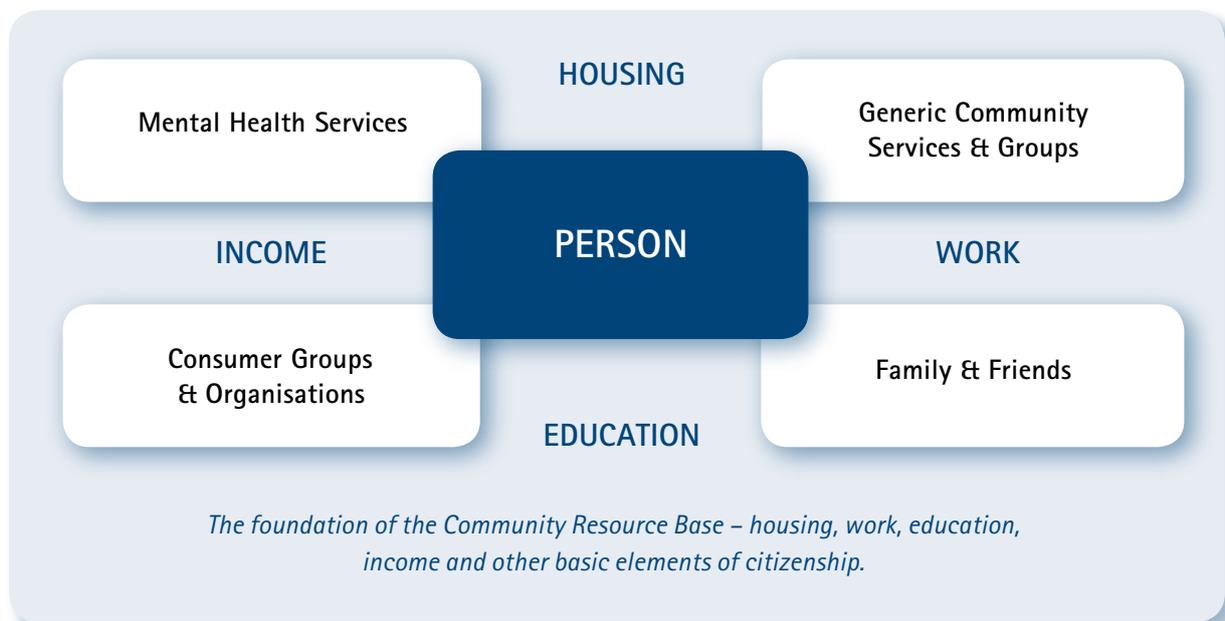
Whose responsibility is recovery?

Recovery emphasises the need for a comprehensive community based service system that works in a positive manner to address the full impact of mental illness (Kalyanasundaram, 2002). This is supported by research which suggests environmental factors, such as family environment, life events, social supports and psychosocial treatments may have a significant impact on the outcomes of people with a mental illness (Strauss et al., 1985).

The Community Resource Base model (Figure 2), stresses the importance of family and friends, generic services and supports, and peers in meeting the needs of people with a mental illness. It also highlights the fundamental rights of everyone to have access to adequate housing, education, income, work, and other basic elements of citizenship. The importance of supports being sourced from mainstream community based service providers is further verified by research which indicates that skills are not easily transferred from the clinical setting (Tobin, 1999).

'For me in recovery I had grown to believe in myself, accepted my situation, my family had accepted me warts and all and I was aware of my fragilities. Acceptance and awareness are vital ingredients to recovery.'
Anonymous

To assist in the development of the community resource base it is important that new ways to distribute power and resources are explored, peer initiatives are supported, participation in service development by people affected by mental illness and their carers is promoted, and coordinated access to generic services and the basic elements of citizenship are improved (Trainor, Pomeroy & Pape,1993).

Figure 2. Community Resource Base (Trainor et al , 1993)

HOUSING

Mental Health Services

Generic Community Services & Groups

PERSON

INCOME

WORK

Consumer Groups & Organisations

Family & Friends

EDUCATION

The foundation of the Community Resource Base – housing, work, education, income and other basic elements of citizenship.

The Community Resource Base model represents a shift in thinking from a service paradigm to a community processes approach. In doing this the elements of citizenship, such as housing, education, income, and work, operate in partnership to support the central person, who is in turn given the power to select the resources they utilise (Trainor et al, 1993). However, the elements of citizenship go beyond meeting basic material needs. It involves membership of a community and being linked through mutually supportive relationships. This incorporates not only social relationships but also civil rights and responsibilities which enhance the recovery process by people connecting with their community through meaningful relationships and activities activities (Onken et al., 2002).

Coordinated and collaborative approach to service delivery

The Community Resource Base model highlights that responsibility for the delivery of supports and opportunities for recovery do not rest exclusively with health. Accordingly, the improvement of mental health services in isolation do not address all the issues related to the support of people with mental illness and their recovery. All sectors, including health, housing, income support, education, employment, justice, police, local government and community agencies, need to take responsibility for the mental health of their community and for meeting the needs of people with mental illness.

However, when health and social support services are provided by various agencies there is also a risk of duplication, service gaps and interventions becoming disconnected and complex. To avoid this and to develop coordinated and collaborative service responses, efforts must be made to cultivate partnerships between key service providers and stakeholders. The importance of developing partnerships between key stakeholders has been highlighted as one of the priority areas of reform in the *National Mental Health Plans 1998-2003 & 2003-2008.* These documents stress the need for formally entrenched partnership arrangements, based on the varying needs and preferences of the individual, to be developed at both the system and service levels.

The need for intersectorial collaboration is also supported in the *Ten Year Mental Health Strategy* (1996) and the *Queensland Mental Health Strategic Plan 2003-2008.* These documents suggests that, while it is not the responsibility of Queensland Health to provide all the components that facilitate recovery, mental health services do have a central role in establishing links with the relevant agencies to ensure the needs of people with a mental illness are met.

The need to work collaboratively is further endorsed by the *Queensland Government Strategic Framework for Disability 2000-2005, the Strategic Plan for Psychicatric Disability Services and Support 2000-2005* and the *Five Year Strategic Plan for People with a Disability 2001-2006 (Housing).* These documents highlight the need for comprehensive working relationships to be developed with people with a psychiatric disability, families, government, community, and service sectors to assist in the collaborative and holistic provision of support.

The concept of sector coordination is also explored in the Queensland *Department of the Premier and Cabinet Strategic Plan 2002-2006,* which endorses whole-of-government coordination on specific issues. Specifically, Goal 2.1 of this document states that *'Government approaches to strategic initiatives and service delivery are (to be) integrated and collaborative'.*

The *Blueprint for Mental Health Services in New Zealand* (1998) identifies three levels at which coordination needs to occur – the individual, the agency, and the sector. At the individual level a 'lead provider' model is proposed as a way to eliminate gaps by one agency taking principal responsibility for the coordination of the individualised support. The development of memoranda of understanding or protocols to identify linkages, expectations, responsibilities, and to foster clear inter-agency communication is also recommended. To enhance coordination at the agency level it is suggested that one staff member take responsibility for overseeing and promoting inter-agency collaboration and that one agency takes the lead in the distribution of inter-agency information. At the sectorial level, the need for all sectors to take responsibility for mental health in a coordinated manner is emphasised (Mental Health Commission of New Zealand, 1998).

The importance of developing partnerships has also been examined in the New South Wales Health document, *Rehabilitation of Mental Health* (2002). This document proposes the establishment of Rehabilitation Development Groups (RDG). These groups work largely at the individual and agency levels to assist in the development, monitoring and management of local rehabilitation services, the expansion of access to community resources and the promotion of coordinated community based care. In addition, these groups are also in the position to inform and lobby for the operation and funding of local initiatives (New South Wales Health, 2002).

Recovery-oriented system

As the basis of recovery is the personal experience of each individual, a range of services and service models need to be considered when supporting the recovery process. When examining the development of a comprehensive and accessible service response it is important to address all the issues associated with mental illness including impairment, dysfunction, disability and disadvantage. Table 3 identifies the fundamental elements that address these issues and foster recovery-oriented service provision (Anthony, 2000).

Table 3.   Essential Services in a Recovery–Oriented System (Anthony, 2000)

Service Category	Description	Consumer Outcome
Treatment	Alleviating symptoms and distress	Symptom relief
Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
Case management	Obtaining the services client needs and wants	Services accessed
Rehabilitation	Developing clients' skills and supports related to clients' goals	Role functioning
Enrichment	Engaging clients in fulfilling and satisfying activities	Self-development
Rights protection	Advocating to uphold one's rights	Equal opportunity
Basic support	Providing the people, places, and things clients need to survive (e.g., shelter, meals, health care)	Personal survival assured
Self-help	Exercising a voice and a choice in one's life	Empowerment
Wellness/ Prevention	Promoting healthy lifestyles	Health status improved

Consistent with the Community Resource Base Model, this approach also stresses the importance of a broader and more inclusive approach to facilitating recovery. In doing this it is important that the components that impact on the lives of people with a mental illness join together to create a comprehensive recovery-oriented system. However, due to the personal nature of the recovery process it is not possible to compile a complete list. Nonetheless, it is possible to examine those elements more likely to have an impact on the individual and their journey of recovery, such as:

★ Peer support, self help
★ Family education and support
★ Mental health services
★ Primary health care
★ Disability support
★ Community infrastructure
★ Housing
★ Vocational rehabilitation/employment
★ Drug and alcohol services
★ Trauma and abuse services

Peer support and self help

People with a mental illness tend to have significantly reduced social networks and as a result risk becoming chronically reliant upon mental health professionals for support. Throughout the literature, peer support has been identified as an important element of a recovery-oriented service system. (Wiston, Flanagan & Rynders, 1999; Anthony, 1993; Fisher, 1994). Often this type of support is facilitated through self-help and mutual support groups, social clubs and clubhouse programs. However, peer support can also be provided more informally through friendship networks and normal community opportunities.

The relationships that develop through peer support are usually informal and characterised by the values of friendship, independence, empowerment, consciousness raising and mutual aid. It is suggested that it is the reciprocal nature of these relationships that enhances self-esteem, personal competence and strengthens support networks. (Wiston, Flanagan & Rynders, 1999).

Through the development of peer support, people with a mental illness are able to become role models and gain inspiration and hope through the positive stories of others. In addition, peer support programs encourage people to express their knowledge and experience in a manner that is not only accessible to each other but also to mental health professionals.

Family education and support

People with a mental illness do not live in isolation. They have families, friends, neighbours and workmates. It must be acknowledged the profound affect these people can have on the recovery of a person with a mental illness. In particular, family relationships are becoming increasingly recognised as a prominent component in the recovery process (New Zealand Mental Health Commission, 1997).

As stated by Mueser, Drake and Bond (1997), there is a compelling link between stress in the family environment and relapse for individuals seriously affected by mental illness (1997). Mounting evidence suggests that people with a mental illness are more likely to have positive outcomes if their families are well informed about mental illness and the resources available, are assisted to develop the capacity to provide support, and are encouraged to partake in collaborative discussions (New Zealand Mental Health Commission, 1997).

Research also indicates that the children of parents with a mental illness have a higher incidence of emotional and behavioural problems than the general population. Consequently, there is an increasing awareness of the need to identify and support these families. Through the development of family oriented strategies, such as planned care, respite services, family-focused mental health services, and in-home help; parents can be assisted to better meet the needs of their children. Children can also be directly supported through interventions that target risk factors and improve their ability to cope with difficult situations. This requires a flexible network of support and again stresses the importance of developing a collaborative system of interagency referral, and liaison (AICAFMHA, 2001).

'It was winter 1978. I was 19 and told by my doctor I was suffering from depression, and he said the words manic depression. Suddenly my whole life changed. I was (on) an out of control roller coaster....rehearsing suicide and inevitably carrying it out......this failed. My defacto wife rang for an ambulance, she saved my life. Everything changed from that moment on. In early August 2002 I received a flyer in the mail.....It was an invitation to join a Writers Workshop. Hesitantly, I decided to make a commitment.....After a year learning to write, I now facilitate the Writers Workshop, and the Bi-Polar support group in Cairns. Presently I'm studying a course at Boston University, Centre of Psychiatric Rehabilitation. I look forward to continue rebuilding my life, and others who suffer from mental illnesses through the 'RECOVERY' process.'
Stephen

'My husband, my daughter and my family from home PNG, constantly send me e-mails to find out how well I'm coping. This also has lifted my spirits and given me strength.'
Taita

It is imperative families, mental health services and service providers work together to ensure families have the help, information, skills and strategies necessary for them to support and maintain positive family environments. This includes working from a philosophy of hope to educate families about mental illness, improving family communication and problem solving skills, developing strategies to reduce substance abuse and stress, providing flexible and individualised treatment, encouraging family members to develop external social supports, and not pathologising or blaming family members (Mueser, Drake and Bond, 1997). Clearly, services need to look beyond the individual and develop strategies to support and address the needs of everyone affected by the illness. Families need to be considered not only as relatives but also as a component able to contribute greatly to the recovery process.

Mental health services

The primary goal of Queensland mental health services is to provide specialised clinical treatment and rehabilitation services that reduce the symptoms of mental illness and facilitate the recovery process. In doing this mental health services are responsible for a range of specialist services and supports that assist those most severely affected by mental illness, their families and other providers.

The *Queensland Mental Health Plan (1994), Ten Year Mental Health Strategy for Queensland (1996)* and the *Queensland Mental Health Strategic Plan 2003-2008* all state that mental health services are provided through an integrated process of referral, intake, assessment, treatment and discharge. These documents also emphasise the role of services in targeting individual needs through the effective use of resources, coordinating services to ensure continuity of care and facilitating access to more appropriate community supports.

The concept of recovery marks a substantial shift in philosophy from the more traditional models of case management and treatment. Recovery is not a concept that can be tacked on to existing services. It represents a significant change in beliefs, services, practices, anticipated outcomes and power relationships (New Zealand Mental Health Commission, 1997).

Services that successfully incorporate recovery concepts into practice do not simply rename existing programs. As noted by Jacobson & Curtis (2000) a conscious effort must be made to change the power and responsibility within the service. This includes initiatives such as education programs, cognitive-behavioural programs, participation in service development by people with a mental illness and their carers, employment of individuals affected by mental illness, peer operated services, relapse prevention programs, coping skill training, crisis planning, innovative contract systems, policy revision, and stigma reduction activities (Onken et al., 2002, Mueser et al., 2002).

This is not to minimise the role of pharmacological treatment in reducing symptoms. In one study of participants who met recovery criteria, 72% considered medication as an essential factor to their success (Sullivan, 1994). In a separate study of individuals with a psychotic illness, 83% reported that prescribed medication resulted in a reduction of psychotic symptoms. However, this study also revealed that 75% of participants using medication also reported side affects significant enough to disrupt daily living (Jablensky et al., 1999). Consequently, while medication can have an immense impact on the recovery process, it is important this occurs through well developed medication management practices.

As recovery requires the active involvement of people with a mental illness, the simple taking of medication will not facilitate recovery nor will the isolated provision of medication meet the complex needs of people with a mental illness. In fact, pathologising life experiences can have a damaging effect and wrong, ineffective and over use of medication can significantly undermine the potential for recovery (Onken et al., 2002). Medication is only one of many tools that can be used to facilitate the recovery process. This highlights the need for collaborative partnerships between individuals and doctors to ensure the effectiveness of medication and stresses the importance of a coordinated approach that looks beyond symptom suppression to identify a range of social processes that complement medication use.

In identifying these social processes, the integration of recovery concepts into the Individualised Care Plan can be of considerable assistance. It is important this is developed in partnership with individuals, incorporating their goals and a comprehensive assessment of needs. This involves a review of the housing, vocational, income and general support needs that would facilitate recovery. Ideally a recovery focused care plan would not be developed by individuals and mental health services in isolation, but rather in collaboration with key stakeholders as part of an integrated service response.

To make the shift towards a recovery-oriented service system, it is important that the culture and orientation of the mental health service supports recovery and that service providers incorporate recovery principles into every aspect of practice. There must be a pervading belief that every person who accesses the service is a whole and unique individual that has the capacity to recover.

Additionally, as appropriately timed interventions play a significant role in preventing the development of disability or the degree of disability, it is critical that consideration of the recovery process be commenced at the earliest possible point. To achieve this, entry point interventions must be focused on individual recovery and actively work towards people exiting the service.

'When I was in the depth of despair medication and punishment didn't give hope, medication alone didn't empower or give direction. Medication complimented by cognitive therapy strategies resulted in a more acceptable quality of life.'
Anonymous

'I have Schizophrenia and I felt I needed to sleep and just needed sleeping tablets. Now I'm on prescribed medication from my psychiatrist I stay calm and sleep well and now have access to my children again. I look after them after schools each day and go for lots of walks.'
Anonymous

Primary health care

The General Practitioner represents an important part of the overall health and well being of people with a mental illness and their families. Consequently, the **G**eneral **P**ractitioner is often the first point of contact when people initially become ill. In the case of individuals with low prevalence disorders 81% had at least one visit with a general practitioner in the past year (Jablensky et al., 1999). As a result primary health care should be addressed as part of a coordinated component of service delivery. This ensures the involvement of several elements of the health care system and does not lead to the presumption that other health professionals will take responsibility for elements of care resulting in service gaps and physical health needs being overlooked (Tobin, 1999).

It is important that primary health care services, including dental and other specialised services, acknowledge their role in the treatment and support of people with a mental illness. In doing this they should be encouraged to provide a recovery-oriented service that is accessible, coordinated, and non-discriminatory, which identifies and treats less severe mental health problems and provides adequate follow-up for those with stable mental health conditions (Mental Health Commission of New Zealand, 1998).

Disability Support

Not all people with a mental illness have a psychiatric disability. Psychiatric disability affects those people who also experience a long term and significant reduction in their capacity to participate in a range of everyday life experiences and activities. It is this loss or deterioration in personal and social functioning which may impact on a range of life activities and result in a disruption of lifestyle and valued social roles. Psychiatric disability is likely to be long term and may fluctuate throughout a person's life (Disability Services Queensland, 2000; Disability Services Queensland, 2003).

Disability supports are distinct from clinical services, as they do not provide treatment or health-oriented services and are not constrained by definitions of diagnosis or treatment (McKenzie, 1994). These supports are complementary to clinical services and aim to empower people to achieve their lifestyle goals and live fulfilled lives in the community through individual, flexible and responsive support.

Disability supports may assist people to make their own choices and decisions, participate in daily living activities, facilitate their involvement in community life, and develop or increase their network of friends or persons who can add value to their lives. Consequently, disability supports play a vital role in the recovery process through maintaining or enhancing social connections and facilitating an identity outside the diagnosis of mental illness. In addition, the *Queensland Disability Services Act 1992* affirms that people with a disability have the same rights as other members of our community (Office of Queensland Parliamentary Counsel, 1999). As a result, many of the underlying principles of disability support and recovery are complementary.

Both the Australian and state governments are responsible for the provision of a range of disability support. Under the *Commonwealth State and Territories Disability Agreement 2002-2007*, Disability Services Queensland is funded to provide accommodation support, community support, community access, and respite. Disability Services Queensland and the Australian Department of Family and Community Services are jointly responsible for advocacy, information and print disability and the Department of Family and Community Services is responsible for the provision of employment services.

Community infrastructure

Mental health services should never attempt to replace natural communities. Rather they should actively work toward being incorporated as part of the wider community (Mental Health Commission of New Zealand, 1998). Literature on recovery repeatedly emphasises the importance of community integration and the need for people with a mental illness to have access to the range of resources available in the community.

Mainstream activities such as churches or clubs offer an important resource to the community and can provide individuals with a sense of purpose and belonging that is separate from their clinical diagnosis. By participating in community based activities many people are aided in their recovery process and assisted in reformulating their identity from 'patient' to 'person'.

Unfortunately, as discrimination against people with a mental illness is still present in our society, access to these activities may be difficult. Efforts must be made to encourage these services and facilities to be welcoming and inclusive of all members of our society and any practices that discriminate be actively challenged. However, it is important that any work to increase accessibility to generic activities does not result in a large and identifiable group accessing community resources. Such work is unlikely to be based on individual needs and is likely to jeopardise the formulation of natural relationships and the development of community inclusion (New South Wales Health, 2002).

Housing

Recent research confirms that adequate, affordable and secure accommodation has a significant impact on the recovery process. In a study by Baker and Douglas (1990) it was found that the availability of appropriate accommodation had a considerable effect on the outcomes of people with a mental illness (Baker & Douglas, 1990).

Research also indicates that most people prefer to live in their own apartment or house rather than live in a residential program, boarding house, single room hotel or with family (Carling, 1995). People with a psychiatric disability are also more likely to be accepted by the community when living in mainstream housing than those living in specialised housing (Department of Housing, 2001). As a result the principles of individual choice, normal integrated housing, and flexible, integrated support must be considered when providing appropriate housing services (Carling, 1995).

The *Five Year Strategic Plan for People with a Disability 2001-2006 (Housing)* is based on the seven strategic directions identified in the *Queensland Government Strategic Framework for Disability 2000-2005*. This document identifies people with a disability as a major client group who often encounter issues relating to housing affordability, discrimination, security of tenure, changes in circumstances, suitability, inability to access housing services and ability to sustain and retain housing. The aim of this strategic plan is to overcome these difficulties and guide the implementation of more effective and efficient housing assistance that better meets the needs of people with disabilities.

Vocational rehabilitation/employment

Studies indicate that less than 15% of people seriously affected by mental illness are in competitive employment. As employment is frequently identified as a primary goal of people affected by mental illness, a lack of desire to find work cannot be assumed as the principal reason for this low rate (Mueser, Drake & Bond, 1997). It is more likely this rate is related to stigma, assumptions about symptomatology predicting work ability, a service system that focuses on work preparation rather than finding real work, and valid concerns relating to the effect of work on disability benefits (New Zealand Mental Health Commission, 1997).

The influence of employment on the recovery process can not be overstated. Work has a powerful impact both psychologically and economically. Employment provides income, structure, social contact, productivity and meaning through a recognisable societal role. Work represents a shift in identity from the 'patient' role to the 'normal' role of worker. It also breaks the cycle of poverty and dependence and leads to increased personal satisfaction and self-esteem (Carling, 1995; New Zealand Mental Health Commission, 1997; Mueser, Drake & Bond, 1997).

In an effort to improve the employment opportunities of people with a mental illness, numerous programs have been developed. These include vocational rehabilitation to open employment, supported employment, transitional employment, cooperatives, work crews and peer run programs.

'One of the hardest things to recover after Hospitalisation or a major episode of illness is a positive identity. In our culture what we do is part of who we are. We need something positive to say and think about ourselves. I can't stress enough the importance of having meaningful employment paid or voluntary as it gives one a positive identity, teaches you new skills, gives back self respect and improved confidence. For anyone recovering from a mental illness it is often difficult to access jobs and to cope with long hours. Having something to do even for an hour or two a week is an essential part of the recovery process.'
Anonymous

Research indicates that these vocational programs are moderately to strongly successful in helping individuals obtain paid employment. However, programs that target the skills and supports required for a specific job and base employment on individual preference appear most successful (New Zealand Mental Health Commission, 1997; Mueser et al, 1997).. In a review of 18 randomised trials it was concluded that supported employment programs show consistently higher rates of competitive employment than other vocational programs (New South Wales Health, 2002).

Supported employment programs aim to provide people with a mental illness with permanent employment through individually chosen work, integrated work settings, and ongoing support (Carling, 1995). These themes are consistent with the principles identified by the *1992 United States National Institute on Disability and Rehabilitation Research (NIDRR) Consensus Validation Conference*, which established individual choice, integrated settings, service linkages, natural supports, rapid placement, job accommodations, continuity of services and proactive orientation as elements of good vocational service practice (New Zealand Mental Health Commission,1997). .

Nevertheless, supported employment programs also suffer from drop out rates of up to 40%. Research suggests that supported employment does not meet the needs of all people with a mental illness and other vocational programs may provide opportunities for those who would otherwise not have pursued employment. As a result, a spectrum of programs must be considered to cover the full range of individual choices and support needs that facilitate career development.

Drug and alcohol services

Over recent years there has been increasing recognition of the high rates of substance abuse among people with a mental illness. For individuals seriously affected by a mental illness being dependent on, or using psychoactive drugs in a harmful or hazardous way, has been estimated to be as high as 75% (Clement et al, 1993). Whilst estimates vary, it is generally accepted that between one half and two thirds of people attending specialist mental health services have co-occuring drug use issues. Consequently, for people seriously affected by mental illness *'dual diagnosis is an expectation, not an exception'* (Minkoff, 2001).

In addition, a significant number of people presenting to alcohol and other drug services have an identifiable mental disorder. Generally about 40% of clients in alcohol and drug services are thought to have co-occurring psychiatric disorders. Research also indicates that as many as 80% of dependent drug users experience some level of mental health distress or problems (Schuckit, 1994).

It is well documented that persons with these co-occurring issues have higher levels of re-hospitalisation, incarceration, suicide, homicide, housing instability, unemployment, financial difficulty, and display less self-care and treatment compliance requiring more complex care (Drake et al., 1989; Drake et al., 1998; Drake & Wallach, 1989; Lehman, 1995; Oesher & Kofoed, 1989; Ridgely & Jerrell, 1996). As a result, the treatment of substance abuse is integral to the recovery of many people affected by mental illness and should be considered as part of any recovery-oriented service system. It is also important that the treatment for people with a co-morbid disorder be individualised, integrated, continuous and unconditional (Mueser, Drake & Bond 1997; Minkoff, 2001). In doing this Minkoff (2001) recommends that a variety of diagnosis-specific strategies be coordinated and combined in an integrated manner, and interventions be individually adapted to address any treatment obstacles that may arise from the combination of disorders.

Trauma and abuse services

Several recent studies have concluded that the rates of abuse among people who attend mental health services are considerably higher than the general population. In a review of 15 studies involving 817 female inpatients it was determined that 50% had experienced childhood sexual abuse, 44% had been physically abused as children and 64% had been both sexually and physically abused. Other studies examining the abuse rates of men indicate similar rates of childhood physical abuse and the incidence of sexual abuse varying between 24% and 39% (Agar, 2002; Read et al., 1998a,). When examining the rates of abuse over a lifetime, a study of people with severe mental illness found the incidence of physical abuse was 71% for women and 67% for men and the rate of sexual abuse was 57% for women and 33% for men (Read et al., 1998b).

Research undertaken by Onken et al (2002) identified abuse and trauma and the issues of internalised stigma, repeated traumatisation by the system and the historical trauma of past abuse, were identified as consistent themes that hinder recovery. However, despite the high prevalence of abuse and its impact on recovery, studies indicate consistently low levels of inquiry and response by mental health professionals to the incidence and treatment of abuse (Nisbet-Wallis, 2002).

It is important that mental health professionals recognise that experiences of abuse and trauma are common to many people with a mental illness and that responses to this abuse history significantly impacts upon their recovery journey. As a result, inquiry of abuse and the facilitation of effective and collaborative short term and long term interventions should be an essential component of a recovery-oriented system. To enable this, mental health services need to formulate policies and training programs that assist in the development of clinical practice in the area of abuse. This includes policies relating to appropriate abuse inquiry and disclosure responses, avenues for therapy including links with abuse treatment services, guidelines to prevent abuse within services, strategies for the reduction of system related retraumatisation, and guidelines for the notification of abuse allegations (Onken et al., 2002).

Conclusion

The concept of recovery marks a substantial shift in philosophy from more traditional models of support and offers an inspiring alternative for people with a mental illness, their families, carers and service providers. After a decade of mental health reform, the recovery concept offers a unifying vision to consolidate achievements to date and move towards the future. However, far more work needs to be done to translate the philosophy of recovery into practice. This requires more than merely renaming existing practice. It involves a cultural and philosophical shift that affects every level of service delivery. Fostering this process and examining implications for practice is the important next step. Through this a recovery-oriented system can be developed and the philosophy of recovery can become reality within the organisations and agencies that play a major role in the mental health, social and emotional well-being of Queenslanders.

References

Agar, K., & Read, J. (2002) What Happens When People Disclose Sexual or Physical Abuse to Staff at a Community Mental Health Centre? *International Journal of Mental Health Nursing (2002)*, 11, 70-79.

Anthony, W. & Blanch, A., (1987). Supported employment for persons who are psychiatrically disabled: An historical and conceptual perspective. Psychosocial Rehabilitation Journal, 11, 5-23.

Anthony, W. (1993). Recovery From Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s. *Psychosocial Rehabilitation Journal*, 16 (4), 11 – 23.

Anthony, W. (2000). A Recovery-Oriented Service System: Setting Some System Level Standards. *Psychiatric Rehabilitation Journal*, 24 (2), 159-168.

Australian Health Ministers (1992). *National Mental Health Plan*. Australian Government Publishing Service. Canberra

Australian Health Ministers (1998). *Second National Mental Health Plan*. Mental Health Branch, Commonwealth Department of Health and Family Services. Canberra

Australian Health Ministers (2003). *National Mental Health Plan 2003 – 2008. Canberra: Australian Government.*

Australian Infant, Child, Adolescent and Family Mental Health Association Ltd (2001). Children of Parents Affected by a Mental Illness Scoping Project (online). http://www.aicafmha.net.au/projects/scoping/file/report.htm (Accessed 28 February 2003)

Australian Infant, Child, Adolescent and Family Mental Health Association Ltd. (2003) *Response to the Consultation Paper for the Third National Mental Health Plan 2003-2008*. AICAFMHA.

Baker & Douglas, 1990. Housing environments and community adjustment of severely mentally ill persons. *Community Mental Health Journal.* 26:497-505

Carling, P. J., (1995). *Return to Community: Building Support Systems for People with Psychiatric Disabilities.* Gilford Press, New York.

Carling, P. J., Allott, P., Smith, M. & Coleman, R. (1999). *Directional Paper 3: Principles of Recovery for a Modern Community Mental Health System.* National Health Service Executive, West Midlands, Birmingham.

Clement, J., Williams, E. & Waters, C. (1993). The Client with Substance Abuse/Mental Illness. *Archives of Psychiatric Nursing,* 7(4), 189-196.

Commonwealth of Australia. (1992). *National Mental Health Strategy*, Commonwealth of Australia, Canberra.

Commonwealth of Australia (1997) *National Standards for Mental Health Services.* Department of Health and Family Services, Canberra

Commonwealth of Australia. (2000) *Disability Services Standards. http://www.dsc.wa.gov.au/cproot/590/2/49_ Standards4pg.pdf*

Queensland Health. *Mental Health Act 2000* http://www.health.qld.gov.au/mha2000

Corrigan, P., Griffort, D., Rashid, F., Leary, M. & Okeke, I. (1999). Recovery as a Psychological Construct. *Community Mental Health Journal, 35 (3), 231 – 239.*

Deegan, P. (1988), *Best Practice (online)*, http://www.senseinternet.com.au/fintry/bestpractice.htm

Deegan, P. (1991) Recovery, rehabilitation and the conspiracy of hope. A keynote address, presented at the Northeast Regional Training Institutes and Conference on Housing and Supports, Burlington, VT.

Deegan, P. (1996). Recovery as a Journey of the Heart. *Psychiatric Rehabilitation Journal*, 19 (3), 91 – 97.

Deegan, P.E. (2002). *Reclaiming Your Power During Medication Meetings With Your Psychiatrist.*

Department of Housing. (2001). *Report on the Interagency Collaboration Improvement Project.* Queensland Government, Brisbane.

Department of Housing (2002) *5 Year Strategic Plan for People with a Disability 2001-2006* (online). http://www.housing.qld.gov.au/publications/five_year_plan/purpose.htm (Accessed 6 Jan. 2003).

Disability Services Queensland. (2000). *Strategic Plan for Psychiatric Disability Services and Support 2000-2005.* Queensland Government, Brisbane.

Disability Services Queensland (2003) *A Way with Words* http://www.disability.qld.gov.au/publications/waywithwords.pdf

Drake, R. E., Osher, F. C. & Wallach, M. A. (1989) Alcohol use and abuse in schizophrenia. A prospective community study. *Journal of Nervous and Mental Disease*, 177, 408–414. (Medline)

Drake, R. E., McHugo, G. J., Clark, R. E., et al (1998) Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: a clinical trial. *American Journal of Orthopsychiatry*, 68, 201-215. (Medline)

Drake,R. E. & Wallach,M. A. (1989). Substance abuse among the chronic mentally ill. *Hospital and Community Psychiatry, 40* 1041-1046.

Fisher, D. B. (1994). Health Care Reform based on an Empowerment Model of Recovery by People with Psychiatric Disabilities. *Hospital and Community Psychiatry*, 45 (9), 913 – 915.

Fitzpatrick, C. (2002). A New Word in Serious Mental Illness: Field begins to engage in debate with major implications for services. *Behavioural Healthcare Tomorrow.*

Hamilton County Community Mental Health Board, 2002. *Recovery: Definition & Components.* (online). http://www.mhrecovery.com/definition.htm [Accessed 1 February 2002].

Harding, C. M. (2002). What is Possible? In Winter Symposium 2002, *Resource Kit Winter Symposium.* The Park Centre for Mental Health, Wacol.

Harding, C. M., Zubin, J. & Strauss, J. S. (1992). Chronicity of Schizophrenia Revisited. *British Journal of Psychiatry.* 161, 27 – 37.

Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V., & Korten, A. (1999). *People Living with Psychotic Illness: An Australian Study 1997-98 An Overview.* Commonwealth of Australia, Canberra.

Jacobson, N.,& Curtis, L. (2000) Recovery as a policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, 23 (4), 333

Jacobson, N. & Greenley, D. (2001). What is Recovery? A Conceptual Model and Explication. *Psychiatric Services*, 52 (4), 482 – 485.

Kalyanasundaram, V. (2002) Recovery an Overview. Unpublished paper prepared for Director General's Report on Mental Health, Brisbane.

Lehman, A.F. (1995) Vocational rehabilitation in schizophrenia. Schizophrenia Bulletin, 21(4):645-656

Liberman, R., Hilty, D., Drake, R. & Tsang, H. (2001). Requirements for Multidisciplinary Teamwork in Psychiatric Rehabilitation, *Psychiatric Services*, 52 (10), 1331 – 1342.

McKenzie, L. (1994). Psychiatric disability and mental illness – is there a difference. *New Paradigm*, June, 3 - 11.

Minkoff, K. (2001). *Behavioural Health Recovery Management service Planning Guidelines Co-occuring Psychiatric and Substance Disorders.* Department of Human Services, Illinois.

Mueser, K., Drake, R. & Bond, G. (1997). Recent Advances in Psychiatric Rehabilitation for Patients with Severe Mental Illness. *Harvard Review of Psychiatry,* 5 (3), 123 – 137.

Munich, R, Lang, M. (1993). The Boundaries of Psychiatric Rehabilitation. *Hospital and Community Psychiatry,* 44 (7), 661 – 665.

New Zealand Mental Health Commission. (1998). *Blueprint for Mental Health Services in New Zealand: How Things Need to Be.* Mental Health Commission, Wellington.

New Zealand Mental Health Commission (1997) *New Direction: International Overview of Best Practices in Recovery and Rehabilitation Service of People with Serious Mental Illness – A Discussion Paper (online).* http://www.mhc.govt. nz/Publications/Publications/New-Directions.htm [Accessed 8th March 2002].

New Zealand Mental Health Commission (2000). *Three Forensic Service Users and their Families Talk About Recovery.* Mental Health Commission, Wellington.

New Zealand Mental Health Commission (2001). *Recovery Competencies for New Zealand Mental Health Workers.* Mental Health Commission, Wellington.

New South Wales Government (2003). *Rehabilitation for Mental Health.* New South Wales Government, Sydney.

Nisbet Wallis, D.A. Reduction of Trauma Symptoms Following Group Therapy. *Australian and New Zealand Journal of Psychiatry,* 36(1), 67-77.

Office of the Queensland Parliamentary Counsel, *Disablility Services Act 1992* (online), http://www.legislation.qld.gov. au/LEGISLTN/CURRENT/D/DisabilServA92_002.pdf

Osher & Kofoed (1989) Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hospital & Community Psychiatry,* 40 (10), 1025 -1030

O'Hagan, M. (1999). *Six Challenges to the Mental Health Sector* (online). http://www.mhc.govt.nz/conference%20Papers/ PapersCP1realising_recovery.htm (Accessed 7 March 2003).

Olofsson, B. & Jacobsson, L. (2001) A Plea for Respect: Involuntarily Hospitalized Psychiatric Patients' Narratives About Being Subject to Coercion. *Journal of Psychiatric & Mental Health Nursing,* 8(4). 357 – 366.

Onken, S., Dumont, J., Ridgway, P., Dornan, D. & Ralph, R. (2002). *Mental Health Recovery: What Helps and What Hinders?* NASMHPD Office of Technical Assistance.

Queensland Department of Premier and Cabinet (2002) *Queensland Department of the Premier and Cabinet Strategic Plan 2002-2006.* http://premiers.govnet.qld.gov.au/

Queensland Government (1996) *Ten Year Mental Health Strategy for Queensland*

Queensland Government (2000) *Queensland Government Strategic Framework for Disability Services and Supports 2000-2005 http://www.disability.qld.gov.au/publications/psychiatric_strategicplan_20002005.pdf*

Queensland Government (1999) *Queensland Disability Services Act 1992 http://www.legislation.qld.gov.au/LEGISLTN/ CURRENT/D/DisabilServA92_002.pdf*

Queensland Health (1994) *Queensland Mental Health Plan (1994)*

Queensland Health (2004) *Queensland Health Strategic Plan 2004-2010* http://qheps.health.qld.gov.au/Qld_Health_ Strategic_Framework.htm

Queensland Health. (2003) *Queensland Mental Health Strategic Plan 2003-2008*. Internal document. Mental Health Unit, Brisbane

Queensland Health. (2001). *Mental Health Act 2000: A Brief Guide to the Act.* Queensland Government, Brisbane.

Queensland Health. (2002). *Smart State: Health 2020. A Vision for the Future Summary Discussion Paper.* Queensland Government, Brisbane.

Ralph, R. O. (2000). *A Synthesis of a Sample of Recovery Literature 2000.* National Association of State Mental Health Program Directors. Maine.

Read, J., & Fraser, A. Abuse Histories of Psychiatric Inpatients: To Ask or Not to Ask? *Psychiatric Services*, 49(3), 355-359.

Read, J., & Fraser, A. Staff response to Abuse Histories of Psychiatric Inpatients. *Australian and New Zealand Journal of Psychiatry* 1998, 32, 206-213.

Ridgely, M. S., & Jerrell, J. M. (1996, December). Analysis of three interventions for substance abuse treatment of severely mentally ill people. Community Mental Health Journal, 32(6), 561-572.

Rudnick, A. (2002). The Goals of Psychiatric Rehabilitation: An Ethical Analysis. *Psychiatric Rehabilitation Journal*, 25(3). 310-313.

SANE Australia. (2001). *The Blueprint Guide to Psychosocial Rehabilitation*. SANE Australia, Melbourne.

Sartorius, N. (1992). Rehabilitation and Quality of Life. *Hospital and Community Psychiatry*, 43 (12), 1180 – 1181.

Schuckit, M.A. (1994). Alcohol and Depression: A Clinical Perspective. *Acta Psychiatrica Scandinavica, Supplementum*, 377, 28-32.

Spaniol, L. (2001). Recovery from Psychiatric Disability: Implications for Rehabilitation Counseling Education. *Rehabilitation Education*, 15 (2), 167 - 175.

Strauss, J. S., Hafez, H., Lieberman, P.& Harding, M. (1985). The Course of Psychiatric Disorder, III: Longitudinal Principles. *American Journal of Psychiatry*, 142 (3), 289 – 296.

Sullivan, W. P. (1994). A Long and Winding Road: The Process of Recovery from Severe Mental Illness. *Innovations & Research*, 3 (3), 19 – 27.

Szmukler, G. (1999). Ethics in community psychiatry. *Australian and New Zealand Journal of Psychiatry*. 33(3). 328 – 338.

Talbot, J. A. (ed.). (1997). *The Year Book of Psychiatry and Applied Mental Health*. Mosby, Boston.

Tobin, M. (1999). Rehabilitation in Mental Illness: What GPs Need To Know. *Current Therapeutics*, June, 47 – 53.

Trainor, J., Pomeroy, E. & Pape, B. (1993). *A New Framework for Support: For People with Serious Mental Health Problems.* Canadian Mental Health Association, Ontario.

Turner-Crowson, J. & Wallcraft, J. (2002). The Recovery Vision for Mental Health Services and Research: A British Perspective. *Psychiatric Rehabilitation Journal*, 25 (3), 245 – 254.

Valimaki, M. & Leino-Kilpi, H. (1998) Preconditions For and Consequences of Self-Determination: The Psychiatric Patient's Point of View. *Journal of Advanced Nursing*, 27(1). 204 - 212.

Wilens, T. E., Biederman, J., Spencer, T.J., & Frances, R. J. (1994). Comorbidity of Attention-Deficit Hyperactivity and Psychoactive Substance Use Disorders. *Alcohol and Drug Abuse*, 45 (5), 421-423.

Wilson, M., Flanagan, S & Rynders, C. (1999). The FRIENDS Program: A Peer Support Group Model for Individuals with a Psychiatric Disability. Psychiatric *Rehabilitation Journal,* 22 (3), 239 – 247.

World Health Organisation (1978). *Declaration of Alma Ata*. International Conference on Primary Health Care. Alma Ata. USSR.

Young, S. & Ensing, D. (1999). Exploring Recovery from the Perspective of People with Psychiatric Disabilities. *Psychiatric rehabilitation Journal*, 22 (3), 219 – 231.