

Department of Health

health

Recovery-oriented practice
Literature review

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Introduction

This literature review aims to provide an overview of relevant literature that defines good practice in mental health care within a recovery paradigm. The literature review is organised into two main sections. The first focuses on literature pertaining to organisational practice, while the second focuses on the practice of individual practitioners. In addition, the literature review focuses on recovery-oriented practice in services working with adults because available literature on recovery is predominantly adult focused. The literature review does not examine broader systemic issues that impact on mental health practice and consumer experiences.

The review entailed a search of key recovery-related terms and articles relevant to recovery-oriented practice within contemporary mental health services. Other existing literature searches related to recovery were consulted and a large volume of relevant resources were gathered from departmental staff, consumer and carer academics, and mental health educators.

Definitions

The concept of recovery emerged from the consumer movement in the 1970s and 1980s, and continues to be utilised and further developed by people with lived experience internationally (Anthony 2007; Slade 2009). The term also has increasing currency in mental health policy and service systems internationally but is employed in a variety of ways in these settings. Consequently, there is some ambiguity around its definition and therefore its translation to practice. To overcome this difficulty, a distinction has been made between what can be termed clinical recovery and what can be understood as personal recovery. Historically, clinical recovery is defined by mental health professionals and pertains to a reduction or cessation of symptoms and 'restoring social functioning', while personal recovery is defined by the consumer and refers to an ongoing holistic process of personal growth, healing and self-determination (Slade 2009). In this document, the term recovery is considered an overarching philosophy that does not equate with a particular model of care, phase of care or service setting but that can be used to guide practice across the full range of clinical and non-clinical services.

As such, recovery-oriented practice describes an approach to mental health care that encompasses principles of self-determination and individualised care. A recovery approach

emphasises hope, social inclusion, goal-setting and self-management. Typically, literature on recovery promotes a coaching or partnership relationship between consumers and mental health professionals, rather than an expert to recipient of care relationship. The concept of recovery therefore represents a movement away from a purely pathological view of mental illness to a holistic approach to wellbeing that builds on individual strengths (Davidson 2008).

The aim of a recovery approach to mental health service delivery is to support consumers to build and maintain a meaningful and satisfying life, as well as personal identity that is self-defined and self-determined, regardless of whether or not there are ongoing symptoms of mental illness (Shepherd et al. 2008).

Definitions of recovery tend to include the following principles:

- self-direction and self-determination
- empowerment of consumers
- individualised and person-centred care
- holistic and integrated care
- non-linear journeys of personal growth and healing
- strengths-based approaches
- peer support
- hope (US Department of Health and Human Services 2006).

As an ongoing process, recovery is not concerned with 'achieving' a state of being 'recovered' via treatment of mental illness. Rather, the literature suggests that recovery is a non-linear process of continual growth (which may be interspersed with occasional setbacks). The pathway is informed by the individual's unique strengths, preferences, needs, experiences and cultural background (US Department of Health and Human Services 2006). Therefore, recovery is a highly personal and individualised journey that cannot be standardised or replicated. With this in mind, the literature outlines a range of practices and behaviours at both organisational and individual practitioner levels that create an environment supportive of recovery.

1. Service-level practice

Organisational culture and commitment

The literature on recovery highlights the importance of organisational culture in facilitating a re-orientation towards recovery in all aspects of service delivery. For recovery to become embedded in practice, a culture that supports recovery and is committed to incorporating recovery values into all organisational processes is essential. To this end, commitment and demonstrated leadership from service management and individual practitioners is necessary (Farkas et al. 2008).

In one case study of organisational change, a number of activities were identified that facilitated a movement towards a recovery approach. These included:

- revising the organisation's goals and aims (mission statement)
- shifting to a consumer empowerment and education model, rather than a purely therapeutic model
- recruiting consumers at all levels, beginning with management
- training for the new consumer workforce in peer support and other community courses
- developing a system of support for peer support specialists
- focusing on meeting new performance targets and flexibly developing new operations (Shepherd et al. 2008).

Other studies of organisational change support this and further propose inclusion of recovery principles in all management processes, such as recruitment, supervision, appraisal, audit, planning and operational policies, as well as incorporation of recovery values and language into all key organisational documents and publications. Some literature recommends that a commitment to increasing personal agency also be reflected in all policies and procedures. For example, the following practices would be routinely undertaken: provision of information and options to consumers; encouragement of self-management; joint planning for crisis management; shared decision making regarding medication and the provision of choice over treatments; and preferences for clinicians (Sainsbury Centre for Mental Health 2009).

Indicators for a recovery-oriented culture include operating hours that allow consumers to be employed elsewhere, consumer involvement in program development and operations, services that help orientate people to the future and an organisation that honours important life events of consumers and staff equally.

An organisation operating in line with recovery principles would:

- believe in an individual's capacity to recover
- consistently engage with people's recovery efforts
- create environments facilitative of the personal efforts of recovery
- not be obstructive of these efforts or processes (Glover 2010).

The principles of recovery might also be incorporated into organisational structures and systems so that practices facilitative of recovery remain in place regardless of changes to management or staff (Mental Health Coordinating Council 2008).

Tolerance of risk

Currently, the majority of mental health service systems worldwide are primarily concerned with risk assessment, management and minimisation, which is an important component of ensuring their duty-of-care obligations are met. The literature suggests it is also important to acknowledge that risk is an inherent part of living with a mental illness and that a risk minimisation approach can, at times, hinder an individual's recovery effort. As a starting point to overcome this challenge, the Sainsbury Centre for Mental Health (2009) posits that risk assessment and management arrangements should be evaluated against recovery principles. In particular, an evaluation of risk policies should examine whether risk procedures unduly decrease people's sense of control, access to opportunities outside mental health services and hope for the future. Procedures should then be redesigned in collaboration with consumers so they retain their effectiveness while being experienced by consumers as more open and transparent.

As a recovery approach involves promoting consumer choice, agency and self-management, a degree of risk tolerance in services is necessary. As such, services may empower people – within a safe environment and within the parameters of duty of care – to decide the level of risk they are prepared to take as part of their recovery journey. In supporting people's recovery efforts, it is necessary for services to articulate the threshold of risk appropriate to the particular service setting. Accordingly, services would provide guidance, training and support to staff on how to reconcile flexibility and responsiveness to people's unique circumstances and preferences with appropriate risk management obligations. This involves working with the inherent tension between encouraging 'positive risk taking' and promoting safety (Department of Health 2007).

Documentation

The literature reviewed suggests that, within a recovery approach, documentation and practice in assessments and reviews should pay attention to people's life ambitions and current assets. Family and friends could contribute to assessments and care planning, thereby building on people's existing resources and support networks (Department of Health 2007). In all documentation, a person's choice of language should be noted and respected (Davidson & Tondora 2006) because language can either encourage or undermine people's recovery efforts and the routine use of certain terminology can potentially inhibit staff understanding of people's experiences. For example, when a person does not stay on their medication, a practitioner may describe that person as 'noncompliant' with treatment. This may occur without the practitioner investigating the broader context of the person's choices, reactions and circumstances, which may include troubling side effects of medication. Therefore, the term 'noncompliant' may not be an accurate or helpful representation of the issues for the person.

Access to information

The provision of adequate orientation for consumers appears in much of the literature on recovery, which suggests that orientation should include information on client rights, complaint procedures, treatment options, advance directives, access to their records, advocacy organisations, spiritual services, and rehabilitation and community resources (Davidson & Tondora 2006; Davidson et al. 2009). The provision of orientation would also be documented in a person's record (Davidson et al. 2009). As a large volume of information is provided at orientation, ongoing information would be available to consumers, as well as carers, family and support people (Davidson & Tondora 2006).

Recovery-oriented services are identified in the literature as ensuring information is available in a variety of formats to enable people to make informed choices. In addition, policies could be established that enable people maximum choice, for example, to access records, incorporate advance directives, get advocacy support, request a transfer to a different practitioner and participate in service planning. Services might also consider how such policies could be clearly publicised and information on people's rights and responsibilities could be made accessible at all times (Davidson et al. 2009).

Staff recruitment and performance

The workforce, in partnership with consumers and carers, is pivotal to achieving a recovery-oriented service system (Mental Health Coordinating Council 2008). Much of the literature recommends that recovery principles be incorporated into all recruitment processes and documentation such as job advertisements and descriptions (Department of Health 2007). Consumers could be involved in recruitment processes in a number of ways such as short-listing applications and sitting on interview panels. Additionally, in order to ensure the provision of person-centred care, services might routinely consider how the mix of staff disciplines and skills in the workforce meet the health and social needs of people accessing the service (Davidson & Tondora 2006; Department of Health 2007).

The importance of an organisational identity that supports effective organisational and staff development within a recovery framework is highlighted in the literature (Mental Health Coordinating Council 2008). For example, competency in recovery practice, knowledge and skills could be incorporated into a range of human resources processes (Davidson & Tondora 2006). Services could also ensure that professional development and learning, supervision, training, research and performance monitoring are consistent and compatible with principles of recovery (Department of Health 2007). A recovery-oriented organisation would also consider it part of everyone's work to monitor quality against recovery principles and this would be documented in performance plans and appraisals (Sainsbury Centre for Mental Health 2009; Shepherd et al. 2008).

Consumer workforce

Some literature recommends that organisations encourage employment of people with lived experience, as well as relevant qualifications (Davidson & Tondora 2006). Consumer workers provide hope and role modelling to both those employed in the mental health workforce and those using the service. Carers as staff are also valuable to an organisation because of their experience with consumers, and the literature suggests carers can be good proponents of family-inclusive practice (Mental Health Coordinating Council 2008).

A consumer (and carer) workforce also demonstrates that the organisation values people's lived experience and serves to actively promote social inclusion (Davidson & Tondora 2006).

Self-disclosure of the lived experience of current employees would also be respected in a recovery-oriented organisation, which would support staff on their own recovery journeys (Davidson & Tondora 2006; Sainsbury Centre for Mental Health 2009).

Consumer feedback

There are a number of ways that services can solicit and respond to consumer feedback to inform recovery-oriented practice.

Use of measures

Measures of satisfaction with services can be routinely collected from consumers and their friends, family and carers, and used to inform strategic planning and quality improvement (Davidson & Tondora 2006; Davidson et al. 2009). Complaints procedures should also be made accessible to consumers and their support people to express dissatisfaction with services (Davidson & Tondora 2006). This data may be used for ongoing practice development, such as professional learning initiatives, because it presents an opportunity for organisations to explore ways of adapting service delivery to attain improved consumer satisfaction. Outcomes data can also be used as a measure of service quality in relation to recovery practice, particularly outcomes against consumer-developed recovery goals (Davidson & Tondora 2006).

Quality audits and surveys

Information about service performance can be collected through local audits and consumer and carer surveys to be used as feedback (Sainsbury Centre for Mental Health 2009). Quality audits might consider include the following:

- how consumers are employed in the organisation, including in direct care
- how meaningful consumer choice and involvement are encouraged in treatment decisions and condition management
- how team leaders demonstrate a commitment to ensuring staff have attitudes of respect and equality for consumers and carers (Sainsbury Centre for Mental Health 2009; Shepherd et al. 2008).

Service planning and evaluation

Organisations may involve people in ongoing service planning and evaluation. Recommendations involving a range of activities to include people in planning and evaluation, such as participation in steering and advisory committees, membership on boards of directors, varied employment opportunities, as well as individual interviews, focus groups, stories, writing, storytelling and public speaking, are all present in the literature. People would be reimbursed for their time and provided with assurance that the results of these activities will be used to inform future activity and make genuine changes (Davidson et al. 2009; Restall & Strutt 2008).

It is asserted in the literature that consultation processes need to be flexible, inclusive, respectful and transparent. All opinions should be valued and confidentiality upheld. The use of clear and inclusive language is also important and processes should take into account participants' schedules and safety, and be conducted in ways that are comfortable for participants (Restall & Strutt 2008).

Services can develop multiple and varied opportunities for involvement and inform consumers about opportunities for participation through a range of media (Restall & Strutt 2008).

Consumer-led training

Comprehensive, consumer-led education and training programs can be routinely carried out for all staff across all professions and at all levels. In this way, trained consumers can be supported as champions of change (Sainsbury Centre for Mental Health 2009) and could be regularly invited to share their stories with current service users and staff (Davidson & Tondora 2006; Davidson et al. 2009). Services would need to consider appropriate debriefing and support mechanisms to facilitate this process.

Evidence-based practice

The literature suggests that a recovery paradigm and evidence-based practice, as the two principal propellants of contemporary mental health service improvement, are complementary (Torrey et al. 2005). However, more work needs to be undertaken to further build an evidence base compatible with recovery principles and to utilise evidence-based tools to support people's recovery (Farkas et al. 2005). The role of services in this regard is to facilitate access to

evidence-based interventions to meet the health and social needs and aspirations of consumers and their families and carers (Department of Health 2007). Keeping up to date with changes in practice and professional development through supervision, appraisal and reflective practice are all important activities for all staff in a recovery-oriented organisation (Department of Health 2007).

Models of care

A number of models of care aligned with a recovery approach are highlighted in the literature.

Strengths-based assessment

In this model of care, a discussion of strengths is the focus of every assessment, care plan and case summary (Davidson & Tondora 2006). Discussions might include the activities, treatments and support mechanisms people have found helpful in the past. Personal goals would also be discussed, and self-assessment tools could be employed to allow consumers to rate their level of satisfaction in various life areas. Services might consider how to build on the strengths in individuals' families, support networks and community, and practitioners would use person-first language (Davidson et al. 2009).

Individual recovery planning

Recovery planning is a collaborative process led by the consumer and facilitated by service staff. The individual has control of who is involved, and when and where recovery planning is undertaken. Goals are defined by the individual and based on the individual's unique interests, preferences and strengths. Discussions focus on the identification of concrete next steps and the language of the plan is understandable to all participants. A flexible range of options are available from which the person can choose the supports that will best assist them in their recovery (Davidson et al. 2009). Where a person finds it hard to remain motivated, the practitioner would act in a facilitative capacity.

People should be provided with information on their rights and responsibilities in receiving services at all recovery planning meetings. This includes informing people about the mechanisms available for providing feedback (Davidson et al. 2009).

In assisting people with recovery planning, services should not expect people to move through a continuum of care in a linear way and should thus ensure that recovery planning

considers a flexible array of options for people to choose from (Davidson et al. 2009).

Partnerships

Partnership models between service and consumer, between service providers, and with community, are consistent with a recovery approach.

In partnership models between service and consumer (and carer, family and friends) services demonstrate an understanding of the person's wider social networks and the contribution made by carers, family and friends to the recovery process. Services are arranged so that accessing mental health care does not disrupt personal roles and relationships (Department of Health 2007).

Recovery-oriented services working in partnership with individual consumers' support networks view health and social care needs in the context of preferred lifestyle and the aspirations of consumers, their families, carers and friends (Department of Health 2007). In doing so, services recognise the rights and aspirations of consumers and their families, acknowledging power differentials and minimising them wherever possible (Department of Health 2007).

Partnerships between service providers (for integrated care) can increase people's opportunities for building and sustaining a meaningful life. Partnerships with housing, employment and other non-mental health agencies recognise the holistic nature of people's needs and wellbeing (Sainsbury Centre for Mental Health 2009), and allow mental health services to assist people to access a range of other important services (Davidson & Tondora 2006; Davidson et al. 2009).

A key aspect of a recovery approach relates to social inclusion through community participation (Sainsbury Centre for Mental Health 2009). The literature recommends that services build relationships with community organisations and have an up-to-date database of community-based opportunities to facilitate the social inclusion of consumers (Department of Health 2007).

Care planning is identified in some literature as creating pathways to community participation. Care should be taken to not replicate a service already available in the community. Thus, adequate knowledge of opportunities, resources and barriers in a person's local community will assist services in challenging stigma and discrimination (Davidson & Tondora 2006).

2. Individual practice

Collaborative relationships

A recovery paradigm promotes collaborative partnerships between mental health professionals and consumers, whereby the health professionals provide information, skills, networks and support to people to manage their own condition and get access to the resources they need. This relationship is characterised by openness, equality, a focus on individuals' strengths and resources, reciprocity and power sharing (Shepherd et al. 2008). The aim of the relationship is to create the conditions in which people have the agency to determine their preferred options and pathways, including for treatment of mental illness. Although legislative frameworks may provide for involuntary treatment, it is the practitioner's approach and behaviour that will primarily impact on people's experiences of treatment. Even when a person is considered unable to make decisions regarding treatment at any given time, practitioners may still enter into a collaborative relationship with the person and respond to their particular needs, concerns and preferences. Advance statements are helpful tools in aiding practitioners to identify and respond to people's preferences in times of crisis, when people may find it difficult to communicate their preferences to practitioners directly.

In the context of a collaborative relationship with consumers, practitioners may find Deegan's notion of personal medicine helpful in understanding how they might operationalise a recovery approach. Deegan (2007) defines personal medicine as:

... the activity that gives life meaning or purpose. It is also self-initiated, non-pharmaceutical, self-care strategies that serve to avoid or decrease psychiatric symptoms, to avoid undesirable outcomes, such as going back to hospital, and to improve mood, cognition, behaviour and overall well-being.

Deegan points out that psychiatric medications can, at times, interfere with personal medicine, which can adversely impact on a person's overall wellbeing. For example, where the capacity to parent forms a core part of someone's personal medicine and side effects of medication render the person unable to care for their children, the medication can be said to interfere with personal medicine, creating what Deegan (2007) refers to as 'decisional conflict' for the person. Equally, a person's psychiatric symptoms may interfere with their

personal medicine. Practitioners who integrate a recovery approach value 'personal medicine' and work to support consumers to make decisions that enhance, and do not adversely impact on, personal medicine.

Decision making

As self-determination and self-management are core components of a recovery paradigm, recovery practice can be understood to promote person-led decision making in accordance with the individual's values, needs, resources and circumstances.

As outlined in the practice guidelines for the Connecticut Department of Health and Addiction Services, recovery planning should honour the 'dignity of risk' and the 'right to fail'. Practitioners offer expertise and suggestions, however, an individual's competency is not questioned nor is their ability to make decisions. The role of practitioners is to provide all the relevant information to support people to consider their full range of options, along with their potential consequences (Davidson & Tondora 2006). In this context, practitioners need to balance consumers' right to take risks without diminishing duty-of-care obligations.

Deegan (2007) has developed a program for supported decision making around the use of psychiatric medication that harnesses her notion of personal medicine. The model consists of three components. First, it involves an interactive peer workshop to support people to identify their own personal medicine. Second, a specialised software program is employed by consumers within the service setting to document information about their personal medicine, decisional conflict and medication goals. This information is then used as a resource in shared decision-making sessions with the treating psychiatrist. Third, case managers specifically trained in strengths-based and recovery practice support consumers in their ongoing recovery efforts and wellness.

Staff skills and qualities

Consumers have reported that stigmatising attitudes can be encountered within mental health services and among other consumers (Department of Health and Ageing 2009). In order for the treating environment to be therapeutic and supportive, service staff should actively challenge stigmatising attitudes and demonstrate attitudes conducive to recovery. The literature posits that the qualities and attitudes of staff are at

least as, if not more, important as their skills and knowledge (Davidson 2008), particularly because their values and attitudes will inform their approach.

A range of positive relationship skills and behaviours are required for staff to practice in line with a recovery paradigm. These important qualities include empathy and encouragement of responsible risk taking (Sainsbury Centre for Mental Health 2009; Shepherd et al. 2008), a belief in people's strengths and resources (Sainsbury Centre for Mental Health 2009; Shepherd et al. 2008) and expression of genuine curiosity in people as authorities on their own lives. Additionally, resourcefulness in focusing on strengths and resources available, respecting the person's wishes, using crises as opportunities for change and ultimately respecting the person are other behaviours essential to recovery practice (Buchanan-Barker & Barker 2008).

Practitioner behaviour

The literature suggests that every staff member should reflect recovery principles and promote recovery values in every interaction, acting to increase consumers' personal agency, acknowledge non-professional expertise, reduce power differentials, increase people's opportunities, and validate hope. Internal pathways might also be created for people to move through the service in the form of referral, assessment, care coordination and discharge, and these processes should be reviewed as to whether they aid or obstruct recovery (Sainsbury Centre for Mental Health 2009).

Other important ways that mental health professionals can practise in accordance with a recovery approach include:

- assisting people to stay well, building support structures and developing contingency plans, joint crisis plans, negotiated safety plans and advance directives that respect people's preferences
- developing partnerships with other agencies designed to meet the diverse range of consumers' needs
- training consumers in self-management and in setting their own agendas when working with professionals
- helping people to define and achieve their goals in ways acceptable to the person
- practising according to an individual's need rather than using standardised solutions defined by professionals

- promoting empowerment approaches such as the Wellness Recovery Action Plan (WRAP) or strengths-based approaches
- reviewing services, therapies and treatments using a recovery lens.

Staff can act as recovery coaches or guides by offering respect, time and persistence in supporting people (Davidson 2008). Clinicians should use interventions that serve to minimise the role of professionals in a person's life and maximise natural supports. Indicators of effectiveness as a recovery guide may include:

- hope and belief in the person when they cannot believe in themselves
- ongoing assurance of people's potential for positive health and wellbeing, even in the presence of symptoms
- interventions aimed at assisting people in gaining autonomy, power and connections with others
- goals written in a person's own words and meaningful engagement of staff with those goals
- team discussions that focus on people's goals and progress, and that review the extent to which advanced statements have been followed
- consumer-led discussions about their hopes, dreams, talents and skills, with the practitioner enquiring 'How can I be of help?'
- assessment of people in relation to their own goals
- assessment, documentation and updating of people's strengths as progress is made
- practitioners working on the basis that as a person grows and develops through their recovery journey, the symptoms become less a defining characteristic of self and more a multi-dimensional sense of identity including strengths, skills and competencies
- people are assumed capable of doing things for themselves and, only if they cannot, are asked about what practitioners can do to help (Cuskelly 2010).

Recovery practice is difficult to define and measure because it is personalised; however, there are particular kinds of behaviours that should be displayed by staff (Sainsbury Centre for Mental Health 2009; Shepherd et al. 2008). A number of good-practice staff behaviours are suggested across the literature on recovery and are outlined below.

Active listening

Active listening refers to staff listening non-judgementally to people as they make sense of their experiences, valuing people's unique stories and helping people to identify their goals for recovery (Buchanan-Barker & Barker 2008; Cuskelly 2010; Sainsbury Centre for Mental Health 2009; Shepherd et al. 2008). In doing so, practitioners help people to tell their stories in the language of empowerment, understanding that people may or may not find diagnoses helpful (Davidson 2008). Although there is a paucity of literature on how to approach and engage with people's experiences during acute phases of mental illness, active listening and corresponding demonstration of empathy and responsiveness can be practised at all times.

Belief and hope

In working in a recovery-oriented way, staff demonstrate a belief in people's strengths and resources, use examples from their own or others' lived experiences to validate people's hopes, and are attentive to goals that take a person out of a clinical recovery lens. Staff also identify non-mental health resources to help people achieve their goals, encourage self-management of mental health problems, routinely discuss people's preferences for mental health interventions, behave respectfully and collaboratively with people, and maintain hope and positive expectations (Sainsbury Centre for Mental Health 2009; Shepherd et al. 2008).

Operating within a recovery paradigm, practitioners convey belief in the improvement of the condition. Practitioners also accept that individuals are allowed the right to make mistakes and express their feelings, including anger and dissatisfaction, without having these feelings attributed to symptoms or relapse (Davidson et al. 2009). Mental health workers also use language of hope rather than despair in talking and writing about people (Davidson 2008).

Self-reflective practice

The recovery literature suggests that practitioners regularly assess the services they are providing by asking themselves: 'Does this person gain power, purpose (valued roles), competence (skills) and/or connections with others as a result of this interaction? Does this interaction interfere with the acquisition of power, purpose, competence or connections

with others?' (Davidson et al. 2009). Practitioners should also be reflective about the values, ideas and attitudes that inform their practice and whether these are aligned with principles of recovery (Department of Health 2007).

Gender sensitivity

Importance is placed on individualised care that is customised according to the particular needs of the individual consumer. As such, sensitivity to differences based on gender, gender identity and sexuality (among a multitude of other differences) is necessary to employ recovery-oriented practice. Gender-sensitive practice acknowledges and responds to differences, inequalities and the varied needs of men and women (Department of Health 2009), recognising that men and women experience mental illness differently and the impact of illness can vary due to gender (Department of Health 2011).

Cultural sensitivity

Mental health services support a population of consumers with diverse cultural backgrounds. Accordingly, a recovery approach involves supporting consumers to build and sustain a positive identity, which may incorporate a cultural identity within a social context. Therefore, recovery-oriented care needs to be culturally sensitive and responsive (Anthony 2000; Davidson et al. 2009). This means that policies and programs should be reviewed in relation to their cultural relevance to diverse groups of consumers, and staff should be culturally competent and responsive (Anthony 2000). Cultural sensitivity should also take into account factors such as age and gender, which may be relevant to people's cultural identity, experiences and needs.

Social and emotional wellbeing

Although Aboriginal Australians comprise a diverse range of cultural and language groups, Aboriginal communities generally conceptualise mental health as social and emotional wellbeing, at both individual and collective levels (Department of Health 2011). Consequently, approaches and interventions that are considered effective for non-Aboriginal people may not be suitable or helpful for Aboriginal people. A recovery-oriented approach that promotes holistic and individualised care may in fact be well suited to ensuring that the particular needs of Aboriginal consumers are met. As such, recovery-oriented practice should be culturally sensitive

and responsive to the particular experiences, understandings, views and community relationships of Aboriginal people. In this way, practitioners operating within a recovery paradigm when working with Aboriginal people would demonstrate genuine interest and responsiveness to the personal and cultural needs identified by Aboriginal consumers. There is not currently a great deal of literature that focuses on recovery and Aboriginal people's mental health wellbeing.

Trauma-informed care

Experiences of trauma are markedly common among people with a mental illness (Department of Human Services 2008). Trauma has multiple, varied, complex and enduring effects on people, which may not be immediately apparent to practitioners (Department of Health 2011). However, some of the behaviours and responses that practitioners observe in consumers may be directly related to trauma. In this context, it is important for practitioners to recognise the significant impact of abuse on people's lives, wellbeing and recovery journeys.

Trauma-informed care involves practitioners individually, and services systematically, ensuring that mental health care is sensitive to trauma-related issues. In particular, admission to mental health facilities can be experienced by consumers as intimidating and alienating; services could take care to avoid practices and behaviours that may retrigger previous experiences of trauma or re-traumatise people. For example, practices of seclusion and restraint may retrigger experiences of isolation, abandonment, confinement or powerlessness associated with abuse that exacerbate the impact trauma and compound a consumer's distress.

Additionally, a trauma-informed service is responsive to disclosure of previous or current abuse. A trauma-informed service undertakes routine enquiry about abuse, and facilitates effective and coordinated responses (Queensland Health 2005) based on individual consumer preferences (Department of Health 2011). Although there may be limitations in terms of the design and layout of services, practitioners and service management can demonstrate mindfulness around people's feelings of personal security and safety, particularly in mixed-sex wards. This may result in consideration, planning, protocols and activities in relation to room allocation, use of gender-specific spaces and shared areas.

In a trauma-informed and recovery-oriented service, treatment of mental health problems could also consider the impact

of trauma in relation to people's recovery, particularly as psychiatric medication may make it difficult for people to address the ongoing impact of trauma on their mental health and wellbeing (McGrath et al. 2007). Consequently, practitioners may find it helpful to consider practices associated with trauma-informed care in supporting people on their recovery journeys. Due to the prevalence of experiences of trauma among people with mental illness and the broad applicability of trauma-informed care, trauma-informed care can be considered appropriate in all service delivery, not just in treatment of consumers with known experiences of previous trauma. A recovery approach can be considered very compatible with trauma-informed care because trauma-informed approaches are typically person centred and involve sensitivity to individuals' particular needs, preferences, safety, vulnerabilities and wellbeing. In addition, trauma-informed care involves recognition of lived experience and empowerment of consumers in decision making (Department of Health 2011).

Family inclusiveness

It is understood that the provision of high-quality specialist mental health services involves inclusiveness and collaboration with families and carers. The literature suggests that inclusiveness of families and carers in mental health service delivery improves the wellbeing of consumers and their families and carers (Department of Human Services 2005).

Family members and carers include people connected with the person or caring for the person who do not identify as carers. This is sometimes the case when children are involved in caring for a family member or parent with a mental illness.

It is important for services and health professionals to acknowledge the people who individual consumers identify as family because families may be composed of biologically or socially connected people, including biological or non-biological parents, same or different sex partners, siblings, extended family, kinship groups and children and young people (Department of Health 2011).

In the context of trauma-informed care, providing family-inclusive care can be difficult in situations where disclosure of abuse has occurred because services have a responsibility to ensure the physical and emotional safety of consumers in their care. In such circumstances, in order to practice in a recovery-oriented way, health professionals should carefully consider the need to balance people's rights, preferences,

safety and best interests. As such, practitioners would work to support the person and to respond to their wishes regarding how best to proceed (Department of Health 2011). However, families require support and understanding even when a practitioner is not in a position to give them information without patient consent.

Social inclusion

There is an indication that increasing social inclusion of consumers is an inherent part of a recovery approach because recovery is a 'social process that involves being with others and reconnecting with the world' (Queensland Health 2005). Social inclusion can be understood as the opportunity to participate in economic, social and civic life (Department of Planning and Community Development 2010).

Much of the literature on recovery highlights the role of mental health service providers in challenging stigmatised attitudes towards mental illness and in enhancing consumers' social participation in the broader community (Sainsbury Centre for Mental Health 2009). Care planning should thus include consideration of new pathways to engagement in the community (Davidson & Tondora 2006). Consideration could also be given to consumers' individual definitions and perspectives of community, and aspirations to be involved in communities of their choosing.

Use of positive language

The literature on recovery consistently highlights the importance of the language used by mental health professionals for recovery-oriented practice (Ministry of Health 2008). Glover (2010) has developed some example language for practitioners to use as a reference in supporting consumers in their recovery or 'self-righting' efforts. However, Glover points out that sample language should only be used as a departure point to establish conversations, and not as a script, to ensure authenticity in the relationship.

Glover (2010) recommends conversations between mental health professionals and consumers that explore consumers' strengths and what they consider important (their personal medicine). Discussions of what natural support systems consumers utilise, how they prefer to manage challenges they encounter, what they've learnt from previous experiences and how they make sense of their experiences. Other sources promote similar use of language (Kisthardt & Rapp 1992).

Other frameworks to guide practice

This section outlines a range of resources from different jurisdictions aimed at providing guidance to individual practitioners. Some of the resources also feature organisation-level guidance, which has been disseminated in the thematic analysis in section 1 on service-level practice.

Fourth national mental health plan

The *Fourth national mental health plan* was developed to further guide reform through a whole-of-government approach following the endorsement of an overarching national policy by health ministers. Social inclusion and recovery is a priority area for action. The actions associated with social inclusion and recovery relate to:

- improving community and service attitudes to reduce stigma
- coordinating the health, education and employment sectors to enhance people's educational, employment and vocational possibilities
- enhancing consumer choice through improved coordination between mental health and primary care services
- adopting a recovery-oriented culture in mental health services, underpinned by appropriate values and principles
- developing integrated programs and partnerships between housing, community, justice and aged care sectors
- implementing a renewed framework for social and emotional wellbeing for Aboriginal and Torres Strait Islander communities.

Sharing responsibility for recovery

Sharing responsibility for recovery was developed by the Queensland Government to establish a shared understanding of recovery and to work towards a framework for recovery across government and non-government agencies.

The document outlines key principles to assist services and health professionals in the provision of recovery-oriented services. The principles state that services should:

- work within a framework of recovery and incorporate philosophies of hope, empowerment and partnership into practice
- encourage and facilitate recovery and wellness throughout every aspect of service delivery

- provide the best help available to everyone and assist people to find the right help at the right time
- understand people in the context of their whole selves, not just their illness
- protect people's rights and treat them with equality and respect
- ensure people set their own goals and measure their own success
- enable people with a mental illness to take on competent roles
- focus on people's strengths rather than concentrating on symptoms and deficits
- be staffed by individuals who are compassionate and competent to assist people in their recovery
- be appropriately utilised by those who require specialist mental health care and ensure that discharge occurs in a timely manner
- facilitate and aid natural support networks and look outwards to assist people to find and use other more appropriate community services, supports and resources (Queensland Health 2005).

UK capabilities for inclusive practice

The UK Department of Health (2007) developed a set of capabilities for inclusive practice at both organisational and individual levels. Below is a synopsis of the capabilities at individual practitioner level.

Working in partnership:

- Work actively to build partnerships to access resources and opportunities for service users.

Respecting diversity:

- Search for community resources, have an awareness of the diversity of customs and practices and values in different social communities, work to develop your own emotional and social intelligence.

Practising ethically:

- Recognise the rights and aspirations of service users and their families, acknowledging power differentials and minimising them wherever possible.
- Demonstrate an understanding of the service user's wider social networks and the contribution made by carers, family and friends to the recovery process.

- Understand the importance of informal relationships, strengths and aspirations in the service user's recovery process and show this in assessment and planning processes.
- Work constructively with the inherent tensions of legal powers and duties versus people's rights to make their own choices and retain control of their lives.
- Display self-regulatory behaviour, highly developed personal insight into your own values and conduct, and transparency in dealings.

Challenging inequality:

- Demonstrate knowledge of legal rights.
- Identify ways that community facilities might accommodate individual service users.

Promoting recovery:

- Have an optimistic approach.

Identifying people's needs and strengths:

- Work in partnership with individual service users' support networks.
- See health and social care needs in the context of preferred lifestyle and aspirations of service users, their families, carers and friends.
- Recognise the multiple levels of inclusion/exclusion a service user may be subject to.

Providing service-user-centred care:

- Support service users to participate in mainstream community settings.

Making a difference:

- Facilitate access to and deliver the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.
- Conduct reviews of inclusion arrangements and regularly collect evidence on what works for service users and carers.

Promoting safety and positive risk taking:

- Empower a person to decide the level of risk they are prepared to take within their health and safety; this includes working with the tension between promoting safety and positive risk taking.
- Include risk of exclusion in assessments and make risk assessments hopeful so the least restrictive alternative is also the most inclusive.

Personal development and learning:

- Keep up to date with changes in practice and seek professional development through supervision, appraisal and reflective practice
- Develop several possible explanations for what is happening in the service user's life and reflect on these.

100 ways to support recovery: A guide for mental health professionals

Rethink is a UK-based non-government organisation that developed a guide for mental health professionals to stimulate critical thinking on recovery and to inform practice (Slade 2009). The report indicates the types of support that may be helpful to people in their recovery efforts.

The guide outlines 100 action points to assist mental health staff in their practice, along with a conceptual framework. The action points for staff pertain to:

- holistic care, partnerships between services and supporting access to uplifting experiences and cultural/community activities
- peer support
- recognising consumers' preferences and wishes
- recruiting staff with recovery competencies
- focusing on wellbeing, capability and strengths, and celebrating successes
- supporting people to identify their goals
- using reflective listening to understand people's stories
- using expertise to help consumers make decisions about their treatment
- focusing on positive risk taking to help develop people's self-management skills
- maximising engagement with consumers' support networks
- using recovery-oriented quality standards and development tools.

New Zealand: Let's Get Real

The New Zealand framework for recovery, *Let's Get Real*, outlines a range of skills necessary for supporting people's recovery. For each skill, the document outlines three levels of competency with associated performance indicators: essential, practitioner and leader. All service employees are expected to display essential skills, while clinicians in a service for two years or more should be at practitioner level, and managers and clinical leaders should display leader competency. The primary skills include:

- working with consumers, engaging meaningfully and in partnership using strengths-based approaches
- working with Maori¹
- working with families, encouraging family participation and ensuring family members, including children, have access to education, information and support
- working with communities
- challenging stigma and discrimination
- implementing legislation, policies, practice, regulations, codes and standards to support people and their families
- professional and personal development, active reflection on their own work and ways to enhance the team to support people's recovery.

Below is a synopsis of essential-level performance indicators against each of the primary skills (Ministry of Health 2008).

Working with consumers

The person:

- establishes a connection and rapport as part of a thorough assessment process and recovery planning
- uses age-appropriate and culturally appropriate protocols and processes
- acknowledges the personal, physical, social, cultural and spiritual strengths and needs of each person, including the interpretation of a person's own experiences
- in day-to-day work applies a basic understanding of definitions of mental illnesses and addiction, a range of therapies and interventions, the effects of psychiatric medications on people, and interactions of these drugs with others and/or alternative remedies

¹ This section of the framework is culturally specific to New Zealand and is not elaborated on here. See page 11 of *Let's Get Real* for this section.

- understands and works to mitigate the physical, social and emotional effects of trauma and abuse on people's lives
- works in partnership with the consumer to develop a plan for recovery that is consumer driven, identifies strengths and needs, and is solution focused
- effectively and inclusively ensures people understand their plan for recovery and facilitates access to any other relevant information
- includes consumers in all decisions about their service and treatment, and seeks feedback.

Working with families

The person:

- recognises that a person's family may extend beyond traditional family concepts
- works in partnership with the person to identify and include family, significant people and other networks to support recovery
- establishes a connection and rapport with the family as part of a thorough assessment process and recovery planning
- works with the family in such a way that they feel heard, informed and supported
- shares relevant information with the family and significant people while respecting the service user's right to privacy
- works to understand family perspectives, including the dynamics within families
- identifies those who can provide support within the community and connects family with them
- understands how the mental health and addiction system works and where their service fits within it
- demonstrates a comprehensive knowledge of community services, resources and organisations, and actively supports people to use them
- understands and uses mental health promotion principles.

Challenging stigma and discrimination

The person:

- understands the impact of stigma and discrimination on consumers, families, services and communities
- understands and acknowledges the impact of language in relation to stigma and discrimination, and role models using language that is non-judgemental and non-discriminatory
- recognises and challenges stigma and discrimination.

Law, policy and practice

The person:

- understands and adheres to legislation, regulations, standards, codes and policies relevant to the role
- recognises and respects the rights of consumers and their families
- supports and assists consumers to exercise their rights.

Professional development

The person:

- works effectively in a team by understanding team roles and respecting and accommodating different working styles
- communicates effectively (orally, in writing, when listening, by other non-verbal means) with a wide range of people
- understands the nature and benefits of research and evaluation
- gathers and uses information to inform decisions relevant to their role
- engages with colleagues to give and receive constructive feedback
- understands and practises self-care
- reflects on their own practice to identify strengths and needs
- understands and engages in supervision
- seeks and takes up learning opportunities.

New Zealand: Recovery competencies

The Mental Health Commission of New Zealand (2001) has developed recovery competencies for training purposes. Everyone in the workforce is required to acquire the recovery competencies at some level, but some may need to develop certain competencies further.

The competencies are outlined below and are broken down into major categories and subcategories (not all of which are included here).

- Understanding of recovery principles and experiences in the Aotearoa/NZ and international contexts.
 - Demonstrate knowledge of and empathy with consumer recovery stories or experiences including the ability to:

- see people in the context of their whole selves and lives, not just their illness
- adopt the storyteller's frame of reference.
- Demonstrate understanding of the principles, processes and environments that support recovery.
- Recognise and support the personal resourcefulness of people with mental illness.
 - Demonstrate the ability to support consumers to deal constructively with trauma, crisis and keeping themselves well including the ability to:
 - support people to find positive meaning in their experience of mental illness
 - support people with self-monitoring of triggers and early warning signs.
 - Demonstrate the ability to support consumers to live the lifestyle and the culture of their choice including the ability to support people to find adequate housing, work and income.
- Understands and accommodates the diverse views on mental illness, treatments, services and recovery.
 - Demonstrate knowledge of innovative recovery-oriented service delivery approaches including knowledge of:
 - consumer-run services
 - a range of education and employment supports and services.
- Self-awareness and skills to communicate respectfully and develop good relationships with consumers.
- Understands and actively protects consumers' rights.
- Understanding of discrimination and social exclusion, its impact on consumers and how to reduce it.
- Acknowledges the different cultures of Aotearoa/NZ and the ability to provide a service in partnership with them.
- Comprehensive knowledge of community services and resources and active support of consumers in using them.
 - Demonstrate the ability to facilitate access to and good use of mental health services.
 - Demonstrate the ability to facilitate access to and good use of other government sectors.
- Knowledge of the consumer movement and is able to support their participation in services.
- Knowledge of family/whanau perspectives and is able to support their participation in services.

A range of resources is also included for each competency.

Ten tidal commitments

The 10 tidal commitments is a well-known model developed by Buchanan-Barker and Barker (2008) that aims to support practice change. The model, developed from practice-based research into nursing, promotes values-based practice using principles of recovery as a foundation for treatment of mental health problems. The tidal commitments are accompanied by 20 related competencies for individual practitioners (see below).

The following is a synopsis of the tidal commitments.

1. Value a person's story, embrace their account and assist them in developing and recording their unique narrative.
2. Respect and reflect the person's own language and metaphors.
3. Develop genuine curiosity in the person's unique experiences.
4. Learn from the person as the expert on their life story.
5. Use all available tools and respond to the person's account of what has worked for them in the past and what they believe will work for them in the future.
6. Keep in mind next steps, imagining and envisioning the way forward with the person.
7. Make time for meaningful interactions with the person.
8. Tap into the person's wisdom.
9. Support the person to grow and make decisions.
10. Be transparent and ensure the person knows and understands what's being done and why, using their language and their records such as care plans.

The 20 tidal competencies (Buchanan-Barker & Barker 2008) articulate the extent to which practitioners apply the commitments. The practitioner:

1. demonstrates a capacity to listen actively to the person's story
2. shows commitment to helping the person record their story in their own words as part of an ongoing process of care
3. helps the person express themselves at all times using their own preferred language
4. helps the person to express their own understanding of experiences through use of tools such as personal stories and metaphors

5. shows interest in the person's story by asking for clarification of particular points, asking for examples or details
6. shows a willingness to help the person in unfolding the story at the person's own rate
7. develops a care plan based, wherever possible, on the expressed needs, wants and wishes of the person
8. helps the person identify specific problems of living and what might need to be done to address them
9. helps the person to develop awareness of what works for or against them in relation to specific problems of living
10. shows interest in identifying what the person thinks specific people might be able to do to help them further in dealing with specific problems of living
11. helps the person identify what kind of change would help resolve or minimise problems of living
12. helps the person identify what needs to happen in the immediate future to help the person make positive steps towards their goals
13. helps the person to develop their awareness that dedicated time is being given to addressing their specific needs
14. acknowledges the value of the time the person gives to the process of assessment and care delivery
15. helps the person identify their own strengths and weaknesses
16. helps the person develop self-belief
17. helps the person develop awareness of changes
18. helps the person develop awareness of how they, others or events have influenced these changes
19. ensures that the person is aware of the purpose of all processes of care
20. ensures that the person is provided with copies of all assessment and care planning documents for their reference.

Conclusion

Although the literature on recovery captures diverse views and approaches about what recovery-oriented practice encompasses, there are some commonalities. A recovery approach is generally defined as an approach to mental health care that promotes self-direction, self-determination and self-management, in the context of individualised, holistic and person-centred support, provided by mental health professionals. Recovery aims to empower consumers as they progress on non-linear journeys of self-discovery, healing and personal development. In order to achieve this, recovery practice often employs strengths-based approaches, partnerships and intensive consumer involvement in the delivery and continuous improvement of services.

The literature highlights a range of service-level activity that can be considered good practice within a recovery paradigm. First, organisational culture and commitment is highlighted as an important factor that facilitates a reorientation towards recovery practice. This involves a degree of tolerance of risk as consumers are encouraged to lead decisions about their care. To this end, services should ensure the provision of ongoing information about rights, responsibilities and treatment options to consumers.

Embedding a recovery approach in practice also requires incorporation of principles of recovery into organisational processes, policies and procedures. In particular, recovery-oriented services ensure staff demonstrate competency in practising in ways compatible with recovery values. A consumer workforce is also put forward across the literature as a mechanism for promoting recovery-oriented service. Consumer involvement in service improvement activities is also identified as important for ensuring service quality in line with recovery.

Also illustrated is a range of activities and approaches that individual practitioners can employ to practise in accordance with recovery principles. The relationship between mental health professionals and consumers is one of collaboration and partnership within a recovery paradigm. Much of the literature promotes a coaching or guiding dynamic between practitioners and consumers, whereby the consumer is considered the authority on their life and wellbeing, and the practitioner offers a range of information, options, tools and expertise to support the person's decision making. Although the appropriate degree of autonomy that consumers exercise in acute services may depend on the acuity of their

symptoms at the time, staff practising within a recovery paradigm consistently display attitudes, behaviours and skills in line with recovery.

In order to practise in recovery-oriented ways, it is imperative that practitioners display attitudes and behaviours that are recovery-compatible. For example, the literature identifies active listening, inherent optimism/belief in people, empathy and the capacity for self-reflection as pivotal skills for practitioners of a recovery approach. Additionally, the use of empowering and sensitive language is essential to recovery-oriented practice.

Responsiveness to diversity is also highlighted as an important part of recovery practice that should be responsive to the particular needs and circumstances of each individual. As such, gender and cultural responsiveness, trauma-informed care and socially inclusive practice are identified in the literature as important components of a recovery approach.

From the literature, it is evident that a reorientation of services towards a recovery approach, and the embedding of recovery principles in practice, requires coordinated effort at multiple organisational levels, as well as the consistent dedication of individual practitioners to practice in recovery-oriented ways. Moreover, the literature highlights a range of activities that services and practitioners can utilise to create an environment more supportive of recovery.

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