ACT Mental Health Consumer Network

Submission:

2nd Consultation Draft: National Recovery-Oriented Mental Health Practice Framework

Submitted via email to:

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ACT Mental Health Consumer Network Submission

This submission has been prepared by the ACT Mental Health Consumer Network in response to the release for comment of the 2nd Consultation Draft of the National Recovery-Oriented Mental Health Practice Framework.

The Network is the peak body for mental health consumers in the ACT. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community. We do this through advocacy, representation, lobbying and active involvement in new developments in the mental health sector, as well as in the wider health and community sectors.

General Comments

The Network is very pleased to see that the 2nd Consultation Draft is significantly improved from the earlier draft. We consider that it provides relevant and positive guidance on the adoption of a recovery paradigm which will effect cultural change in the delivery of mental health services. We are also very pleased to see the recognition of the civil rights background to the recovery movement, and the attempt to ensure that the concept of recovery is located within the broader concept of the civil rights of consumers.

The document does still have limitations. Overall, we think that it needs to more clearly privilege the consumer voice as the central and crucial voice in decision making. While we welcome the material on particular marginalised groups, we consider that some of this material is equally applicable to 'mainstream' consumers and services and that this should be more clearly stated. We would also like to see a greater recognition of the importance of trauma informed care throughout the Framework, not just in relation to specific groups.

There are also some places where it is not clear on first reading that the document is summarising a particular academic's views, or that material is a quotation. An example is the three pages of quotation of the Recovery Standard (pages 13 – 15). We suggest that putting this in a box might make clearer that the whole three pages are quoting the standards and its principles. Overall, we suggest that further work be done on formatting to highlight important points and to ensure that it is clear when the Framework is discussing others' views.

Specific Comments

Acknowledgement

Page 5, paragraph 3:

Second sentence: We do not agree that the opening clause of this sentence "Given that a significant proportion of the mental health service workforce has 'lived experience' of mental health problems either in their own lives or those close to them" is useful. The recovery paradigm should assist in breaking down the conventional demarcation between consumers and staff whether or not the staff have lived experience. We suggest deleting this clause.

Last sentence: While we understand that the Framework is not intended to deal with implementation in any detail, we suggest that the need for a focus on implementation to accompany the Framework be highlighted here.

Language through a recovery lens

We appreciate the respect shown for the importance of appropriate language and in particular language that focuses on the person as actor, rather than recipient.

Page 8, paragraph one:

As written, the focus is on the consumer's self-stigma, rather than the external causes. We suggest turning this sentence around to make clearer that the external factors are disempowering and can cause self-stigma, along the following lines:

> Words and language are critically important in the mental health field where discrimination, disempowerment and loss of self-esteem can cause people to battle with self-stigma.

Purpose of the Framework, Page 9

First paragraph*:*

While we agree that the primary intention relates to practice in specialist mental health services, a Recovery based approach will involve services that are not specialist mental health services. We suggest that this paragraph should also acknowledge the need to work with other services, and look outside specialist mental health services.

Fourth paragraph:

We support the view that the Framework will provide the impetus for the development of new service models, including peer-run services. In addition it is important to recognise that the implementation of recovery principles will require greater access to advocacy services for individuals, as well as the development of and support for self-advocacy.

Defining a recovery-oriented approach, Page 10, first dot point:

This is an example where the sentence should be turned around so that the focus is on the consumer experience, rather than the service's expertise. The point would be better made if the sentence were revised along the following lines:

> Mental health services developing and drawing on the experiences and resources of people with lived experience of mental illness, as well as their own expertise and resources.

Second dot point:

This point and a number of other parts of the document refer to people taking responsibility for their own recovery or wellbeing. We suggest this is too narrow a focus, and that the Framework should refer to people being offered the opportunity to take responsibility. In

addition, the reference to people as they 'assume' an active role implies that they have never had that. We suggest revising this dot point as follows:

> Mental health services supporting people as they are offered the opportunity to take responsibility for and reclaim an active role in their life, mental health and wellbeing.

Defining recovery-oriented mental health service delivery, Page 11, second paragraph:

The Network has some concerns about the use of terms such as 'evidence based' and 'best outcomes'. Each begs the questions – by whose reference point? It should be clear in the Framework that the evidence on which practice is based should include the consumer experience and consumer led research, not just evidence such as academic or medical research that does not have consumer input. In the same way, the Framework should clearly state that the judge of what are the best outcomes for individuals are those individuals themselves.

Page 11, penultimate paragraph:

The Network is pleased to see the recognition of the particular responsibility of Australian services in relation to Aboriginal and Torres Strait Islander people. In the second sentence, dealing with Stolen Generations, we suggest that this responsibility is not limited to recognising the nature of the trauma, it should also include responding to it. This could easily be included by adding 'and respond to' after 'recognise'.

In addition, it is important that the Framework not limit the concept of trauma to particular groups. The Network would like to see a section, in this initial Purpose and Definitions section, on the importance of recognising and responding to trauma in any individual and recognition that trauma informed care is an important element of a recovery approach.

Defining mental health services, page 12, first paragraph:

We suggest that the definition of services would benefit by clarifying that 'early intervention' means 'early in illness or early in episode'. We are also concerned that psychosocial disability has not been included in the list of conditions people are affected by, and suggest it should be substituted for 'psychiatric disability'. We consider that 'psychiatric disability' is a narrower term which locates the disability with the individual and that 'psychosocial disability' more accurately reflects the interaction between the individual and society that result in disability.

Recovery through the eyes of lived experience

We appreciate the importance placed on reflecting a range of views on the concept of recovery.

Recovery and diversity, page 18 – 19:

The Network is concerned about this section. We agree with the first sentence, although it would assist if there was some indication of what research is being referred to. However, many consumers do not subscribe to a view that they have 'one true identity' or a 'true

self'. We understand the use of this term in the context of particular issues, such as gender identity or sexual orientation, but do not accept it as a useful concept. For many, identity is not a single or immutable concept. Rather identity is relational, and multi-faceted.

Further, this section appears to indicate that a consumer's 'true identity' is that of a person with mental illness. While we agree that this is one aspect of a person's identity, and that harm can result from attempting to hide it, we do not agree that having a mental illness supersedes all other aspects of identity, such that it constitutes one's 'true identity'.

We suggest that this section be recast so that it deals with the harm resulting from seeking to conceal elements of oneself, and the compounding effects for consumers of discrimination based on ethnicity, race, culture, sexual orientation or other attributes.

From concepts and theory into practice

The interconnectedness of personal recovery and 'clinical recovery', page 21:

The Glover quote is problematic for some consumers, who believe that the focus should always be on personal recovery. Rather than using it as the introduction to this discussion, we would prefer that the reference to Glover's work be moved to much later in this section, after the material covering research by Wood et al and Davidson et al.

Page 22, first paragraph, first sentence:

If the Framework is to embody a consumer focussed approach, the reference to assistance to 'manage' the illness should be amended to 'self-manage' the illness, so that the primacy of the individual is reinforced.

Page 22, dot points:

We are concerned that these dot points seek to standardise a collaborative model, and one which is too limited. Not all collaborative models will have all these elements, and most will have other elements as well. A strength of the draft Framework is that it does not generally seek to standardise particular models. We would prefer these dot points be deleted.

Understanding personal recovery efforts and processes, page 22:

We think this section provides a useful discussion of different views of recovery issues and processes. However, we would like to see the opening paragraph acknowledge that 'the struggle' might also result from initial trauma, or retraumatisation by interactions with the mental health system.

Page 23, First set of dot points, second dot point:

The Network has concerns about the concept of 'a new identity', and would like to see this revised or restated so that it does not assume a 'single identity' for an individual.

Glover dot points, first dot point:

The concept of 'realising' one's strengths implies that this is occurring for the first time. Our view is that moving from the passive to the active is an act of reclamation, not realisation.

Supporting recovery in a diverse Australia

The Network is pleased to see this section and supports the importance of consideration and discussion of specific issues and communities. We are concerned, though, that the concept of trauma is not sufficiently included in the generic principles and practice section. Trauma is not limited to Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse populations. We suggest that the generic principles and practice should include a section on trauma informed care, rather than simply one dot point in which experience of trauma is included as one factor. An appropriate place may be on page 34, before the paragraph dealing with age.

Infants, children and families, page 39, first paragraph:

The last two sentences of this paragraph are a very important overarching statement. We suggest that they should be moved to the earlier section dealing with recovery oriented service delivery.

Page 39, last paragraph:

This paragraph, and the quote in particular, shifts from discussing recovery approaches with infants and children and their families to discussing parenting support as part of an adult's recovery. We found this shift rather confusing.

Rural and remote communities, page 43, second dot point:

We acknowledge the practical difficulties of providing services in rural and remote communities, but are concerned that use of technology should not be seen as a substitute for personal interaction. Rather, practices to enhance face to face opportunities for professional support and development can appropriately be supplemented by appropriate use of technology.

Domains of Practice

Page 47:

The Network agrees that the four domains of practice are appropriate. We would like to see the first one amended slightly to refer specifically to 'people with lived experience', to ensure that it is clear that it is these consumers and their carers, not staff or service providers, who are meant to be central.

Page 48, Capabilities:

We would like to see sexual orientation added to the list of characteristics in the fourth dot point, as it is not otherwise covered.

The Network also considers that an additional dot point should be added to the 'Enabling and supporting personal recovery capabilities', along the lines of:

Acknowledging and working with experience of trauma

This is an important capability for all service providers which is not otherwise covered.

Overarching Capability: Promoting a Culture and Language of Hope and Optimism

Page 51 – 52:

This is a positive and appropriate set of behaviours, attitudes and skills etc. However, we are concerned that overall this capability embodies a glass ceiling approach for consumers. The consumer role appears to be limited to being the recipient of services, or 'peer support'. We suggest that it should be made clear that mental health practitioners may include people with lived experience and that promoting a culture of hope and optimism should include envisaging a world where consumers lead services.

In the Knowledge section at the bottom of page 51, we would like to see the research point amended so that it does not assume that researchers and service providers are 'experts' who are not consumers. Consumer led research is fundamental to ensuring that services, treatment and care are focussed on the needs and views of consumers. We suggest that language such as 'collaborate with consumers in researching ...' would be more appropriate.

Practice Domain: Person 1st and holistic

Page 53, Skills eg, third point:

The Network strongly believes that it is inappropriate to assume that all people with mental illness should be medicated, even with the potential to subsequently withdraw from medication. We consider this point should be revised so that it is clear that medication is an option, but not a necessary, treatment.

Page 54, Knowledge eg:

Second point: We suggest this could be improved by substituting 'consumer approaches to recovery' for 'recovery approaches'. This would assist in placing the consumer experience and the views of consumers at the centre of the discussion, and reduce the risk of this knowledge being perceived as by and for non-consumer experts.

Fourth point: We do not think trauma resides 'in' a person. We suggest that this point be revised to refer to 'the high prevalence of trauma experienced by service users'.

Page 62, Working with families, carers ...:

The Network recognises the important and beneficial role that families, carers and significant people can play in a person's recovery. However, it must also be recognised that for some people, families and carers can be a root cause of mental health issues, and contact with them can impede recovery. It is therefore critical that the language in this section recognises the consumer's right to choose whether or not, and the extent to which, families are part of their recovery journey. We do not think that use of language such as

'where possible' or 'where appropriate' is sufficient, as it leaves open the question of who makes the decision whether involvement is possible or appropriate.

We therefore suggest that the last sentence of the opening paragraph be amended by replacing 'where possible' with 'where the consumer chooses'.

Where families are involved, we do not consider that they should be seen as part of a 'treatment team'. We would prefer that the sentence refer to 'partners in care' but not include 'and treatment'.

Page 63, Skills eg, first two points:

The Network supports the desirability of working with a consumer's support networks in many cases. However, the first point here could be interpreted as indicating that a service should build relationships with a person's family whether or not the consumer wishes that family to be involved in any way. A service provider's contact with families should be subject to the consumer's views.

The second point, dealing with supporting consumers' relationships with family etc, should be clearly subject to caveats such as choice, safety and protection (some relationships should not or cannot be rebuilt).

Practice Domain: Enabling and supporting personal recovery

Page 64, Attitudes eg,:

We strongly support these points, and the way in which they are expressed. This change in attitude alone would significantly reform mental health services. The last point in particular is crucial to implementing a recovery-oriented approach.

Page 65:

Skills eg: We agree that these are good examples of the required skills. However, we suggest that the last point should be reworded, so that it focuses on self-advocacy, supported by advocacy by services. As currently worded, self-advocacy appears to be something to work towards, but not actually support in action. We suggest rewording along the following lines:

> Support and build capacity for self-advocacy in the pursuit of an individual's recovery goals and objectives as well as advocating effectively on people's behalf

Good Practice eg, second last point: We support these examples of good practice, but suggest the second last point should refer to 'retraumatisation of service users', rather than the experience of trauma.

Good Leadership eg, second last point: The Network is concerned that this point is rather nebulous. We would prefer to see a reference to limitations being reduced or minimised as much as possible, as well as to removing them.

Practice Domain: Organisational commitment and workforce development

Page 71, Good Practice eg

The Network agrees that these are examples of good practice. However, we would like to see the examples fleshed out to accommodate and celebrate collaboration, rather than focussing on individual practitioners.