Psychiatric and Mental Health Nursing has established itself as Australia and New Zealand’s foremost mental health nursing text and is an essential resource for all undergraduate nursing students. This new edition has been thoroughly revised and updated to reflect current research and changing attitudes about mental health, mental health services and mental health nursing in Australia and New Zealand.

Set within a recovery and consumer-focused framework, this text provides vital information for approaching the most familiar disorders mental health nurses and students will see in clinical practice, along with helpful suggestions about what the mental health nurse can say and do to interact effectively with consumers and their families.

The fourth edition has a strong focus on the mental health nurse’s experience and provides consumer perspectives, giving students invaluable insights into the lived experience of consumers covering a variety of mental health disorders.

New to this edition:

- 3 new chapters:
  - Physical health
  - Mental health promotion, prevention and primary healthcare
  - Challenging behaviour, risk and responses
- New addresses emerging issues, such as:
  - The transitioning of mental healthcare to primary care
  - The development of peer and service user led services, accreditation and credentialing
  - Mental Health Nurse Incentive Program

About the authors

KATIE EVANS
RN, BA, MLitSt, PhD

DEBRA NIZETTE
RN, DIPAPRSc (Nursing Ed), BAppSc (Nursing), MNursSt, Credentialed MHN, FACN, FACMHN

ANTHONY O’BRIEN
RN, BA, MPhil (Hons), PhD, FNZMHN

e evolve

Visit evolve.elsevier.com for your additional resources:
eBook on Vital Source
Resources for Students and Instructors
  - Student practice questions
  - Test bank
  - Case studies
  - Powerful consumer story videos

Activate your eBook + evolve resources at evolve.elsevier.com
## Contents

Foreword vi
Introduction vii
About the authors ix
Contributors x
Reviewers xii

### PART 1
Preparation for psychiatric and mental health nursing 1
1 The effective nurse
   Louise O’Brien 3
2 Recovery as the context for practice
   Vicki Stanton, Barbara Tooth and Simon Champ 17
3 Historical foundations
   Katie Evans 43
4 Professional, legal and ethical issues
   Phil Maude and Anthony O’Brien 66
5 Settings for mental health
   Julie Sharrock, Phil Maude, Lina Wilson and Michael Olasoji 91

### PART 2
Influences on mental health 119
6 Mental health theory and influence across the lifespan
   Debra Nizette and Patricia Barkway 121
7 Trauma, crisis, loss and grief
   Rachel Rossiter and Robin Scott 148
8 Physical health
   Andrew Watkins and Tanya Park 178

### PART 3
The people with whom mental health nurses work 197
9 Mental health and wellness in Australia and New Zealand
   Wendy Cross, Kim Ryan, Anne Brebner and Tish Siaosio 199
10 Working with families in mental health
    Kim Foster, Kim Usher and Kerry Hawkins 222
11 Indigenous mental health in Australia and New Zealand
    Deanne Hellsten and Hinorea Hakiaha 237

### PART 4
Mental disorders that people experience 339
12 Disorders of childhood and adolescence 251
   Deb O’Kane and Kristin Henderson
13 Mental disorders of older age 269
   Wendy Moyle
14 Intellectual disabilities 291
   Charles Harmon, Philip Petrie and Chris Tua
15 Forensic mental health nursing 315
   Brian McKenna, Tessa Maguire and Trish Martin

### PART 5
What mental health nurses can do to help 497
16 Mental health promotion, prevention and primary healthcare 499
   Tom Meehan
17 Mood disorders 370
   Peter Athanasos
18 Personality disorders 391
   Michelle Cleary and Toby Raeburn
19 Anxiety, trauma and stress-related disorders 408
   Anna Elders
20 Eating disorders 433
   Gail Anderson and Peta Marks
21 Substance use and comorbid mental health disorders 469
   Peter Athanasos

### Glossary
632

### Index
642
Foreword

Well into the new century, much that was once hoped for and seemed only fanciful has become reality in the techniques and workings of psychiatric nursing. The new technologies that we routinely use now give the possibility of new understandings of the working of the human brain. Yet what does this new knowledge really tell about a person's experience of being human?

Increasingly nurses learn not only from textbooks like this one, but also directly from cyberspace, which has become part of the working environment in ways that we could have never imagined. Cyberspace will also inform your learning throughout your career as a mental health nurse.

More than ever before people are actually finding community in cyberspace, perhaps at the cost of family and local communities. This may be one of the greatest challenges to shifting how and where mental health nurses' workplaces will actually occur. Already many professionals are in competition with the websites of NGOs that claim to represent and inform mental health consumers, and certainly we cannot ever imagine that mental health is not a politically influenced realm.

Cyberspace also enables many more consumers of services to have access to competing ideas, and a critique of the professionals who work with them. The emergence of the consumer movement in mental health and increased legislation to recognise human rights have aimed to put the consumer at the centre of your work on a daily basis.

Recovery has been put front and centre in your work with people with mental illness; however, that comes not only from theory but also from the daily experience of being with people. The theory you are learning in this text will only become reality the more you spend time with consumers in a range of settings. At the beginning of your career reading this text you probably have many ideas about best practice that you want to use; however, I would like to think that at the end of your career you will have more questions than you did at the beginning. Such is the mystery of the human condition. Perhaps the hardest thing to learn is to keep an open mind even on a trying day.

For all these changes, this century is already confronting us with challenges many could not have imagined. Climate change and global conflict have added to the trauma and misery of countless millions, as huge populations have been traumatised, many having to move from their homelands. The rise of terrorism like many movements in this century demands specialised strategies for care and help.

Past efforts to work with most people with mental health problems in the community have had many benefits but led to an erosion of long-term care for those who still unfortunately cannot find the recovery they would want for themselves.

No text can fully introduce you to the human dimensions of every extreme and every nuance of the human mind, troubled or fragile, or just highly sensitive to our world in different ways, that you will encounter throughout your career. But it is hoped that this text will give you the foundations for those ongoing enquiries.

My colleagues remind me that perhaps the best strategy is the hardest, which is to approach each relationship with consumers from the stance of ‘what would I want my care to look like?’ or ‘what would I see as good nursing if I was the consumer?’

Simon Champ BA (Visual Arts), PostGradDip (Visual Arts)
Practising Artist
Introduction

We are pleased to introduce our fourth edition of *Psychiatric and Mental Health Nursing* and to inform you about the changes we have made to the content and welcome Anthony O’Brien from the University of Auckland to the editorial team. Anthony has always been a contributing author, and now he is a worthy successor to Ruth Elder who is enjoying her retirement after 35 years in the service of mental health nursing. Anthony’s knowledge has been invaluable in keeping our comprehensive Australian and New Zealand focus balanced and contemporary.

*Psychiatric and Mental Health Nursing* was conceived in 2002 as the first comprehensive Australasian mental health nursing textbook. The book was a response to the need we as academics felt to provide Australian and New Zealand nurses with an accessible local text, designed to actively engage undergraduate nursing students with relevant examples describing the people and conditions they encountered in their learning and working environments. With the help of our contributing authors, selected for their expertise in the field of mental health, we created a local alternative to overseas productions that focused on social, cultural, legal and legislative contexts foreign to us, our students and our mental health nursing colleagues. As the text has evolved over the past 15 years, these goals have remained our primary concern. Although we now have some local competition, our regular, stringent revisions ensure that *Psychiatric and Mental Health Nursing* will continue to be a most valuable and influential text, grounded in the realities of mental health nurses’ everyday learning and working lives.

We promote the effective mental health nursing of consumers/service users who experience problems caused by mental distress and illness, while maintaining an awareness of historical influences on contemporary practice and service delivery. We have maintained our traditional focus on a broad theoretical and philosophical basis for mental health nursing while envisioning the mental health nurse as a practitioner with a recovery orientation who is highly skilled in a wide range of effective interventions.

Nurses work with people, so recovery-informed practice and person-centred care remain our primary priorities. We are privileged that the internationally known consumer, author and artist Simon Champ agreed to write the Foreword and co-author Chapter 2. Simon was one of the first consumer advocates in Australia in the documentary *Spinning Out* (Deveson 1991) and he has been a catalyst for debate and change as an advisor on the first National Strategy for Mental Health, a board member of SANE Australia, an early member of Schizophrenia Fellowship NSW and an invited speaker and teacher nationally and internationally.

Our fourth edition has been revised extensively to reflect the changing views about mental health, mental health services and mental health nursing in Australia and New Zealand. We have increased the number of sections from three to five, to better focus the contents, and to address emerging issues such as the transitioning of mental health care to primary care, the development of peer and service user led services, accreditation, credentialling and the MHNIP (Mental Health Nurse Incentive Program). Along with chapters on the most familiar clinical syndromes that mental health nurses and students will see in clinical practice, we have introduced new material in the areas of mental health promotion, physical healthcare and challenging behaviours.

Our aim throughout was not merely to describe the consumer’s experience or diagnosis, but also to propose ways that the nurse can go beyond passive listening and offer constructive suggestions about what to say and do to help the consumer.

- Part 1 *Preparing for psychiatric and mental health nursing* explores what it means to be a nurse; the history of mental illness and mental healthcare; the consumer and recovery-focused practice; the political, legal, ethical and professional contexts of practice; and the wide variety of settings in which mental health nurses work.
- Part 2 *Influences on mental health* aims to contextualise the influences upon both the nurse and the person with a mental disorder, examining
theories about mental health and wellness across the lifespan and within societies and cultures, as well as how physical health, trauma, crisis, loss and grief can affect a person’s mental wellbeing.

- Part 3 The people with whom mental health nurses work examines specific populations that the nurse will encounter in Australia and New Zealand: indigenous peoples; children and adolescents; older people; the families of mental health consumers; those with an intellectual disability; and people who have become involved with the criminal justice system in a forensic setting.

- Part 4 Mental disorders that people experience develops a better understanding of the major mental illnesses; examines DSM-5 diagnoses, interventions and effective treatments; and incorporates the client’s experience of mental illness.

- Part 5 What mental health nurses can do to help is the active part that brings together the interventions and expertise mental health nurses can offer in clinical situations: mental health promotion; prevention; primary care; assessment and diagnosis; risk assessment; psychopharmacology; and therapeutic skill development.

Rigorous reviews were commissioned both before and after this revision. Reviewers were enormously supportive of the changes we have made. References have been updated, although we believe that the five-year rule does not apply to seminal references. References to DSM-IV TR have been updated to DSM-5, which we chose to use because it is a consistent diagnostic system that is widely used in both countries and internationally and we believe that nurses need to be aware of how diagnostic categories are used in practice and in research.

Lists of useful websites, nurses’ stories and consumer stories have been added to every chapter, and we have included many new authors to add to the contemporary, current practice-based approach. Each chapter is structured beginning with key points, key terms and learning outcomes, and concludes with questions and exercises that will facilitate teaching and learning. Critical thinking challenges, class engagement activities, nurses’ stories, case studies and research briefs encourage an active awareness of the complex issues related to mental health and illness. These resources are supported by the Evolve website from which readers can access more learning materials and case studies.

One of the unique features of Psychiatric and Mental Health Nursing has always been the nurses’ stories. Every chapter incorporates nurses’ stories—short vignettes illustrating the oral, traditional knowledge possessed by practising psychiatric mental health nurses—to assist students to develop insights about the world of clinical practice. Each editor has spent a lifetime working in mental health nursing, in practical, academic and managerial roles. Our own early experiences of hospital training led us to fear that much of the concentrated practical and mentoring aspects that enlivened and enhanced our training could be lost as nurses age and leave the profession. Indeed, many of our original contributors have left the workforce in the past eight years, and with every year that passes it seems to us to be more imperative than ever to gather, utilise and preserve the skills and knowledge of existing practitioners of mental health and psychiatric nursing.

In this new edition you will discover many new chapters and authors and other chapters that have been rigorously revised. Significant changes from the previous edition include:

- Chapter 4 Professional, legal and ethical issues incorporates Chapters 4 and 5 from the 3rd edition into a new chapter that addresses aspects of the Australian and New Zealand politico-legal context, and the professional and ethical issues that guide and regulate mental health nursing practice.

- Chapter 6 Mental health theory and influence across the lifespan merges Chapters 8 and 9 from the 3rd edition into a chapter that links mental health nursing theory to the lifespan approach to formulate a more holistic approach.

- Chapter 8 Physical health is a new chapter. It addresses the physical health of people with mental health problems and conditions that have an association with an increased risk of mental health problems.

- Chapter 10 Working with families in mental health is a revision of Chapter 24 from the 3rd edition, revised and renamed to more specifically address working with the families of people with mental health problems.

- Chapter 22 Mental health promotion, prevention and primary healthcare is a new chapter that engages with the ways in which early intervention can either prevent or alleviate the effects of mental health problems, and how nurses are increasingly involved in different primary healthcare services.

- Chapter 24 Challenging behaviour, risk and responses is a new chapter. Risk assessment can be found in different contexts in many chapters, but this dedicated chapter presents a range of risk assessments specifically focused on challenging behaviours.

We thank the students, academics and mental health professionals who have supported and accepted what we have to say. We hope that our text will continue to have a wide appeal because of its practical approach and the support it offers students and teachers as well as practitioners in any setting who work with people who have a mental health problem. In an environment where mental health nurses are moving towards greater professional autonomy and technical and professional evolution is continuous and inevitable, we want above all to stress the importance of a personal and humane approach to psychiatric mental health nursing practice.

Katie Evans
Debra Nizette
Anthony O’Brien
Chapter 2
RECOVERY AS THE CONTEXT FOR PRACTICE
Vicki Stanton, Barbara Tooth and Simon Champ

KEY POINTS
• The primacy of the consumer voice is central to all current mental health contexts and areas of practice.
• The ultimate goal of mental health practice is to value and facilitate the personal recovery of all individuals. This includes promoting their personal agency, connectedness and social inclusion; self-determination; and their active participation in society. It also relates to how they can negotiate the range of resources they need to remain active citizens in the community of their choice, even during periods of mental distress.
• The quality of a person’s relationships is a key determinant of their quality of life.
• The recovery paradigm provides both the framework to consider what may be necessary for people to have a meaningful life and the context and guiding principles for all mental health practice.
• The context of mental health nursing practice is dynamic and ever-changing, responding to new ideas about what people need in order to live a meaningful and contributing life.
• The recovery paradigm re-conceptualises the roles of mental health professionals to re-emphasise the therapeutic use of self, specifically how to ‘be with’ rather than ‘do to’.
• National and international laws protecting people’s basic human rights provide the legal context for recovery-informed practice within the recovery paradigm.
• Mental health policy and plans provide the sociopolitical context for practice and the implementation of services that, ideally, are based on the recovery paradigm.

KEY TERMS
• citizenship
• community-managed organisations (CMOs)
• connectedness
• consumer voice
• enabling environments
• human rights
• non-government organisations (NGOs)
• peer support
• peer support worker
• personal agency
• personal narratives
• recovery
• reflection
• rehabilitation
• self-determination
• social inclusion
• stigma
• strengths
• supportive environments
• trauma-informed care
LEARNING OUTCOMES

The material in this chapter will assist you to:

- identify the key importance of each person's unique experiences and histories within the context of their whole life, a part of which may be in mental health service systems
- describe the centrality of the person's lived experience to your role as a nurse and your capacity to 'be with' people on their personal journey
- demonstrate an understanding of the role your attitudes, values and beliefs play as key factors in what you say and do when you work with people, and of the role your theories and your life experiences have in this process
- begin to appreciate the complex interaction between the current contexts that influence mental health practice
- appreciate that human rights and the international laws that protect them are central to the mental health field in general and to people who experience mental health challenges in particular
- identify the key differences in the way nurses conceptualise their role and their practice between the recovery and medical paradigms
- describe the principles of recovery-informed practice and the importance of hope and optimism in recovery
- explain the rationale for the shift in mental health to the recovery paradigm, which values the primary role of expert knowledge that comes from the lived experience of severe mental health distress
- appreciate the value of reflective practice and continually developing self-awareness, in particular your reaction to witnessing people's distress and fears.

INTRODUCTION

It is revolutionary when you truly understand recovery (Davidson et al. 2010). In the context of this book, it must be made crystal clear that recovery is about the person living a good life in their community. In reality, mental health and community services play only a small, but important, part in people's lives. The vast majority of a person's recovery occurs outside of services. People who work within such services can get a skewed view that they are central to the person's life. They are not. They are there to support the person and not get in the way of whatever they need in their journey. It is within this context that this chapter introduces students to the richness and depth of the many facets of recovery. It explains why it is the current context for mental health policies, plans, service provision and practice not only in Australia and New Zealand, but also in many countries worldwide (Slade et al. 2014). The chapter also addresses how recovery differs from previous approaches in mental health.

In keeping with the importance of the centrality of people's lived experience of mental health challenges, Simon Champ co-authors this chapter. Simon was one of the first consumer advocates in Australia and has been a catalyst for debate and change. He was an advisor on the first National Strategy for Mental Health, served on the board of SANE Australia and was an early member of Schizophrenia Fellowship NSW. He played a major role in the documentary Spinning Out (Deveson 1991), has been a speaker and teacher both nationally and internationally, and is an author and artist. It is a privilege to have his contribution.

The consumer movement has been the main driving force behind the introduction of the concept of recovery into English-speaking countries; fundamentally, it is about the protection of people's human rights. Therefore, the Universal Declaration of Human Rights (1948), the Convention on the Rights of Persons with Disabilities (1975), and the United Nations Declaration of the Rights of Indigenous People (2008) underpin the recovery paradigm. Both Australia and New Zealand support the declarations and convention mentioned.

The chapter starts by looking at recovery as the current context for practice, how it is defined, the tensions in defining it, how it has evolved and how it is currently understood. This section tracks the history underlying recovery, the key differences between recovery-informed and traditional practice, and how to translate the recovery approach into practice. The chapter concludes with recovery-informed service provision.

To make sense of mental health nursing practice requires an understanding of other factors that may influence it. These include social and cultural factors and the attitudes, values and beliefs that guide our thinking. People's thinking changes over time and this is determined by their own experiences and by changes in thinking about what constitutes appropriate practice. In mental health in the past few decades, the rate of change in thinking about practice has been significant and it will continue to be so. This chapter addresses some of the major shifts in thinking that influence our understanding of what mental health nursing practice entails.

It can be tempting to think that mental health nursing is a discrete area of practice of little value to the general nurse, but this is far from the truth. In fact, it is argued the principles underpinning recovery-based mental health practice also underpin all areas of nursing practice. The fundamental concepts and principles underlying mental health nursing are considered so important to general nursing practice that they have been incorporated into undergraduate nursing courses in Australia and New Zealand. The comprehensive course is intended to provide a holistic approach to nursing care and a basis for later specialist practice.

In addition, at some point in their lives one in five people in Australia will experience mental distress severe enough to be diagnosed and warrant intervention from a mental health professional. Physical illness exacerbates such distress and people cannot isolate
parts of themselves in their interactions with general health professionals. Therefore, it stands to reason that general nurses frequently work with people experiencing mental distress.

For many students, this chapter will probably raise more questions than it answers. If so, it has achieved one of its objectives. It is not possible to address here all a nurse needs to know about recovery to become a competent practitioner. To do this you will need to engage in a journey of continuing professional development in recovery-informed practice and competency.

**RECOVERY AS THE CONTEXT OF PRACTICE**

The current context of mental health practice is one of major transformation. The focus has changed from the traditional biomedical approach towards a recovery-informed approach. Everyone working in or connected with the mental health field is being called upon to answer the question: How will what we do assist people to live a contributing and meaningful life in their chosen community, just like every other citizen? This is a key question of the recovery paradigm.

The National Framework for Recovery-Oriented Mental Health Services: Policy and Theory defines recovery as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’ (Commonwealth of Australia 2013a, p. 25). While recovery is a simple concept that all people want, the implications for services and everyone within them are huge, especially when you truly understand what recovery means. How well recovery is understood and the leadership that occurs in all service and community systems impacts the rate of transformation in mental health. To guide the beginning nurse’s understanding of recovery, the different context in which the term ‘recovery’ is being used in mental health services will be explored. It covers such contexts as a person’s journey of recovery, a recovery framework, recovery-informed practice and the recovery paradigm itself. Let’s look at these more closely.

**Recovery as a personal journey**

First, it is important to understand recovery is primarily and foremost a personal journey that can only be undertaken by the person. People who have or have had mental health challenges are the experts on personal recovery through experience. No-one can make a person recover, do it for him or her, or be the expert on the person’s experience. This is key to recognising how services, everyone involved in mental health and the community as a whole can support, promote and facilitate the person’s self-directed recovery journey. It is paramount that each person’s unique personal journey drives the care, service provision and service structures they need. Glover (2012) refers to recovery as a natural self-righting process people undertake to grow beyond any distress that interrupts the balance of daily life. Recovery starts with the person; they determine what they need and which services and supports would work best for them. Care in the context of recovery is always collaborative and driven by the person experiencing mental health challenges. Glover also emphasises the constant need to recognise and uphold the personal nature of recovery and to support the self-applied effort and learning that a person engages in. Glover cautions that mental health workers could default to seeing recovery through a clinical gaze but she advises workers to use their skills to be in relationships with people in ways that support the ongoing, progressive nature of their personal growth.

**Recovery paradigm**

A paradigm is a distinct set of concepts or thought patterns, including theories, research methods, hypotheses and standards for what constitutes legitimate contributions to a field (Oxford English Reference Dictionary; The Free Dictionary). You will already be familiar with the technological paradigm that informs the biomedical model. The recovery paradigm identifies the wide range of knowledge and research that is important to inform the mental health field and the wider community, including the body of knowledge gained from personal recovery.

Maintaining hope and optimism are overarching principles in recovery (Commonwealth of Australia 2013a) as is citizenship (Rowe 2015). Key features of the recovery paradigm include the need for self-determination, personal agency, the importance of social inclusion and having choice in a range of services. Valuing the person’s imperatives rather than clinical imperatives drives the recovery paradigm: it represents a change in values (Slade 2009). A review of policy documents indicates that the term ‘recovery’ was introduced as a paradigm into New Zealand mental health services in 1998 and into Australian services in 2003.

Dan Fisher, a prominent psychiatrist who has identified as having been given the label of ‘schizophrenia’, states that the recovery paradigm views mental health issues as challenges that a person can grow beyond, through the assistance of culturally appropriate, trauma-informed services and natural supports in the process of the person building a full and gratifying life in the community of his or her choice (Fisher 2011).

**Recovery framework**

A framework is a subset of the recovery paradigm. Frameworks provide the structure to inform cohesive service delivery and guide principles of practice (recovery-informed practice). There are many different recovery frameworks. They can be frameworks to guide service provision, principles of practice or competencies. Often
these reflect what the person proposing the framework thinks are most important. Sometimes the terms ‘framework’ and ‘paradigm’ are used interchangeably. The Tidal Model (Barker & Buchanan-Barker 2004) is one such framework specifically developed for nurses. You are encouraged to look at their website.

**Terms used to describe people who experience mental health challenges**

Before moving on in this chapter, it is important to address the terms used to describe people who experience mental health challenges. The terms most commonly used to identify people with mental distress are ‘consumer’, ‘(psychiatric) survivor’, ‘user’ and ‘ex-user’. ‘Person with a lived experience’ is a relatively recent term.

The Consumer Coalition first used the term ‘consumer’ in the United States of America in the early 1980s (Clay 2002). The term ‘survivor’ is also used in the United States because of its resonance with the human rights movement, highlighting the fact that treatment often does not meet people’s needs and in many cases violates their basic human rights. In contrast, the terms ‘user’ and ‘ex-user’ are used in the United Kingdom, while in Australia ‘consumer’ and ‘client’ are generally used. The term ‘patient’ is considered too bound up with illness, the medical model, deficits and the disparity in status between person and professional. It also implies a more passive role, with the person concerned being the recipient of care. The term ‘client’ has similar connotations to ‘patient’, while the term ‘consumer’ implies a more active role, with the person having rights, responsibility and a more equitable relationship with the care provider. The key mental health organisations and policy documents in Australia use the term ‘consumer’. See Box 2.1 for key mental health organisations and policy documents in Australia, peak consumer and carer advisory groups and consumer participation policies and frameworks.

Since language conveys meaning, we prefer the expression ‘people who have experienced mental health challenges’, because it is part of the spectrum of human experience we may all have. The reality is **everyone** is susceptible to developing mental health challenges. To normalise this and to reduce stigma, there are a number of high-profile public figures in sport, politics, the arts and business coming out and talking about their own mental health challenges. These include: Australian politicians Andrew Robb, John Brogden and Kate Carnell; sports person Ian Thorpe; and public personalities Jessica Rowe, Stephen Fry and Ruby Wax. An extensive list can be found at http://amandagreenauthor.co.uk/300-famous-people-celebrities-who-have-suffered-with-mental-illness-or-issues-help-highlight-the-stigma-in-our-society.

---

**Box 2.1 Key mental health organisations and policy documents in Australia**

- Mental Health Australia (an independent peak national body for mental health that has a wide range of important resources), www.mhca.org.au
- National Mental Health Commission (numerous important resources), www. mentalhealthcommission.gov.au

---

**Defining personal recovery**

Only the person who has the lived experience can define personal recovery. This poses the dilemma of finding a definition that is widely accepted. There are numerous definitions of recovery in the literature. Anthony’s definition continues to be prominent and informs mental health policies and plans in a number of countries around the world (Slade et al. 2014). Anthony states that recovery is:

> a deeply personal, unique process of changing one’s attitudes, values, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness (Anthony 1993, p. 14).

There are other definitions of recovery espoused in seminal works of prominent consumers, academics and clinicians (Borg & Kristiansen 2007; Chamberlin 1997;
Curtis 1998; Deegan 1993; Davidson 2003; Fisher 2011). Key features espoused by these authors include:

- doing something worthwhile
- being involved in things not related to their own problems
- having ordinary discussions with others
- being included in and connected to communities
- being included in ordinary work roles and settings

Where it is recognised that everyday ups and downs of life in these settings are an intrinsic pattern to be experienced rather than pathologised

- regaining belief in oneself
- recognising losses of rights, roles, responsibilities, decisions, potential and support then finding out what the person wants and how they want to achieve it

- making meaning out of one’s experiences

- recognising that recovery is not the same as being cured, as it is a process with no endpoint or destination

- being aware recovery is an attitude, a way of approaching day-to-day challenges and being in control

- having a life outside mental illness.

The above definitions demonstrate that people who have mental health challenges want to live a life like every other citizen. Recovery is not unique to people who experience mental health challenges. Every individual will have challenging life events from which they recover. This is an essential part of normal human growth and development. The difference for people with mental health challenges is the additional significant barriers they face. They often experience social disadvantage, social isolation and have difficulty getting back into mainstream society for a variety of reasons. Frequently, they have difficulty finding accommodation, obtaining meaningful work, having meaningful connection with others, achieving an adequate income and feeling safe. Simon Champ’s story in Consumer Story 2.1 tells of some of his experiences and the challenges of living with mental health distress.

The many descriptions of recovery demonstrate that it is a multifaceted and deeply personal experience. It is not possible to find a single definition with which everyone agrees. This was demonstrated in a large Australian study on recovery from schizophrenia (Tooth et al. 2003). One aim of the research was to identify a consumer definition of recovery. This was not achieved with the 60 participants: there were as many views as there were participants. Overwhelmingly, the participants had not actually thought in terms of recovery until they agreed to take part in the research. They stated that they were just getting on with their lives, highlighting the very personal and complex nature of people’s understanding of their experiences of mental distress. The nebulous nature of recovery continues to be identified in recent research (Le Boutillier et al. 2011).

Students need to be aware of how they use language and terms such as ‘recovery’ with the people with whom they work. Such terms may have little or no meaning to them, or their meaning may be different from your own understanding. Successive generations of people have experienced very different practices and treatments. Therefore the current terminology of recovery may not be familiar to older people. A critical point here is that it does not matter what the term is—it is the meaning people make of their own experience and the principles and values that underpin recovery that really matter.

To illustrate the above point on differences in personal meaning, in the Spinning Out documentary (Deveson 1991), Simon Champ came up with the quirky mnemonic for schizophrenia. For him schizophrenia means Special Creatively Heightened Individual Zanily Overly Perceptive Humorous Really Emotional Needing Individual Assistance.

**TENSIONS IN DEFINING RECOVERY**

The recovery paradigm and recovery frameworks acknowledge the centrality of each consumer’s voice in terms of care and service provision. However, there is justified concern among consumers that they are not being listened to or heard because of a lack of dialogue, collaboration and shared decision making with professionals (Kidd et al. 2015). There is a growing perception that recovery is being colonised by professionals and services as a result of consumers not being heard. Researchers (Le Boutillier et al. 2011; Cleary et al. 2013; Bird et al. 2014) found that mental health practitioners can have different meanings for recovery that are not consistent with the consumer voice on what constitutes recovery. Some practitioners considered recovery in terms of symptomology or improvement. Others emphasised certain aspects of recovery over others in their practice, depending on their own personal views. In addition, some professionals and organisations embrace the term ‘recovery’ but do not fully understand what it means. They continue to practise in old ways while claiming to be recovery oriented, leading to fears the promise of recovery has been hijacked by professionals (Mental Health ‘Recovery’ Study Working Group 2009).

Similarly, Morrow (2011) found consumer advocates argued that the recovery paradigm had been co-opted into the biomedical frame. When this happens, the biomedical frame becomes dominant and downplays the social determinants of health, structural disadvantage and social exclusion that are so critical to mental wellbeing. Here, part of the tension is between the term ‘clinical recovery’, which has sprung up to refer to medical management of symptoms and functioning in acute services, and the term ‘personal recovery’, where the concerns are significantly broader and apply no matter where the person is in services (including acute care through to the wider community). A more constructive approach is to consider the value of both views and see how they can complement one another (Glover 2012; Slade 2009).
Consumer Story 2.1
Simon’s story: living with difference and mental health challenges

I have mentioned elsewhere (Champ 1998) how schizophrenia severely ruptured the relationship I enjoyed with myself prior to my mental health challenges. To have the lived experience of a mental illness/disorder even for a brief period can be distressing and discouraging not only for the person going through the experience, but also their family and friends. At best for some a mental illness/disorder can sensitize one to the world in new ways that if harnessed can be a productive force in someone’s life. Yes, many people do recover and while some recover, stigma never lets them live as such. Implicit in the treatment of people affected by and living with a mental illness there were always seemingly unrealistic expectations of their ‘recovery’. People’s expectations of ‘prognosis’ were either too high or, discouragingly, too low.

The constantly changing nature of my experiences with schizophrenia over many decades changed my relationship with myself many times and in a number of different ways. For myself my diagnosis initially came with hope. I was in the euphemistically named ‘nervous breakdown’ category, breaking down in my final year in high school and leaving school to work and then repeat the HSC. I loved studying art, biology and English. I was an English migrant who had arrived with my family trying to adjust to country schools in Australia and already falling behind. I moved many times whilst trying to study at a tertiary level with very supportive parents. I was trying to make sense and meaning in a life that was more and more chaotic. My diagnosis moved up a notch to ‘paranoid schizophrenic’. On reflection this was a label I applied to myself, becoming my illness was a very disempowered position. My diagnosis moved on to ‘schizoaffective disorder’. I found myself in libraries trying to understand these diagnoses. My struggle for equilibrium and meaning led to stark realities. The prognoses I came across were highly discouraging. They gave me little hope.

Always the question of being mad, bad or both challenged me. I was too young and too immature to really understand much of the 1960s civil rights and counterculture movements that questioned these labels.

When I was recently an inpatient I wanted the nurses to know how distressing I found the environment around me. No-one seemed to understand the impact of watching others and the incomprehensible interactions between people who were distressed. I wanted nurses to mirror back to people or confront them on how their behaviour affects others whilst at the same time realising this was a hard task for nurses when behaviours are those they may not have come across before. Just as people with mental health challenges have to reflect on their own issues, so too, do nurses, I want nurses to be able to keep an open mind, to keep hope alive especially for those around the person when they are at their worst and experiencing the most challenges.

There were many professionals who provided me with hope along the way. Others could not get through to me in spite of their best efforts. I have realised how I did use denial. I now try very hard to see what I enjoy about me and around me. Time can be a healer, time can be a teacher, and bring awareness of things that have been long hidden. The nurses I most valued were those who, rather than imposing their reality on me, helped me to explore where reality and wellbeing might exist for me.

There have been many opportunities afforded to me as an activist and advocate. I have been able to travel widely and meet people including some of the best minds in mental health and art. It has opened doors for me. It has given me insights into others and myself. In the last few years I have become less concerned with the wider picture of thinking on mental health and I have tried to return in a more positive way to my practice as an artist. As hard as it is, I once again am able to find solace and new insights into many fields of endeavour, ironically including nursing. I am at my best when I’m engaged through my art and my interactions with others. Making a meaningful contribution is important to me.

What I hope for in the future is that the extraordinary amounts of new information about the world we live in and the people we are can enable far more options to be available for people, no matter what their experiences of living with a mental health disorder. These greater options must be timely and readily available to enable people to get the help they deserve. I hope nurses and more broadly everyone in the community come to see the wonder that is the human being.
WHAT RECOVERY IS NOT

Recovery is not rehabilitation

It is not always easy to distinguish between the terms ‘rehabilitation’ and ‘recovery’. The terms have been used interchangeably and also they are spoken about as if recovery has replaced rehabilitation. The concept of recovery has not replaced rehabilitation but it has changed the way it is practised. Traditionally, psychiatric rehabilitation has been provided for people who experience severe and enduring forms of mental illness, with the primary aim of reintegrating the person into the community. Professionals, including nurses, assessed the person’s deficits to determine their rehabilitation needs and the person then attended a rehabilitation service where programs (often run by nurses) would address these skill deficits. This approach to rehabilitation has been criticised by Deegan (1988; 2004) and O’Hagan (2011) because it requires people to progress through predetermined skills-based training programs regardless of individual needs. In addition, such rehabilitation programs were determined by ‘experts’ based on what they thought was best for the person.

In 1988 Deegan made a useful distinction between recovery and rehabilitation in mental health services that is still valid today:

Disabled persons are not passive recipients of rehabilitation services. Rather, they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability… Rehabilitation refers to services and technologies that are made available to disabled persons so 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 disability (1988, p. 11).

Recovery is not cure

In his 2005 book Recovered, not Cured, McLean makes some very important points about the complexity of personal experience that makes this so. In medicine, recovery from illness is the absence of symptoms of the disease or disorder, and a return to the person’s premorbid level of functioning after a designated period of time. For example, for some types of cancer, a person is considered recovered after a period of 5 years without symptoms. None of these conditions apply to recovery from mental health challenges for the following reasons:

- People can consider themselves to be in recovery and still have the experience of mental distress.
- Mental health challenges are transformative in nature and challenge people’s concepts of normality, making the return to a premorbid level of functioning meaningless.
- Recovery is also described as an ongoing process, so timeframes are likewise meaningless. The rate of recovery varies for each person. For some it may occur in small incremental steps. Indeed, the crisis or mental health challenge may arise because of the need to recover from one situation to another.

PERSONAL NARRATIVES

Personal narratives are essential to recovery-informed perspectives and for determining what is important for any individual in their journey of recovery. Box 2.2 about the recovery of Mary O’Hagan, a prominent international consumer educator and consultant, illustrates the tension between what people say is important to them and what professionals and the system focus on. This tension is underscored by the fact that although many people find meaning in their madness, the people they turn to for support view madness primarily as pathology and something to be managed and medicated.

Box 2.2 Story of recovery: Mary O’Hagan

In common with so many people who experience mental distress, Mary describes her madness as the loss of self, the solid core of her being. While this core is not evident during times of madness, it returns stronger, renewed and ready to go again. Madness is a crisis of being that is a part of the full range of human experience. Mary explains: ‘My self is the solid core of my being. It is like an immutable dark sun that sits at the centre of things while all my fickle feelings, thoughts and sensations orbit around it. But my self goes into hiding during madness. Sometimes it slides into the great nothingness like a setting sun. Sometimes it gets trampled in the dust by all the whizzing in my body and mind… Sometimes my madness strips me bare but it is also the beginning of renewal; every time I emerge from it I feel fresh and ready to start again.’

Mary had to make friends with rather than fight her madness; get to know, understand and respect it—a complex process. ‘My madness was like a boader coming to live in my house, who turned out to be a citizen from an enemy country. Knowing I might not get rid of him meant I had to make peace with him and learn to understand his language. Once I got to know the boader, he was no longer the stereotypical enemy, but a complex character that deserved some respect.’

Mental health professionals did not find any value in helping Mary to understand the meaning in her madness. Nor did they allow her to tap into her own
Is Mary O’Hagan’s experience an isolated one? Is it an old story that would not happen today? No. Glover (2012) presents the stories of two women and their personal experiences of mental distress managed in Australia by involuntary inpatient admissions. The women’s perceptions of their care include that they were not helped to make sense of their experiences, felt stripped of their power and were not responded to as people but as ‘diagnostic categories’. Their experiences were described using the language and meaning of the professional knowledge base; their own meaning and language for their experiences were not encouraged or valued. What makes Glover’s work so powerful is that while both women had very similar experiences, one story took place in 1985 and the other in 2010. The latter occurred at a time when services were promoting their model of care as recovery-informed, leading Glover to ask, what has actually changed in the past 25 years? The link to personal stories in Box 2.3, and the very influential keynote address Simon Champ gave at the Congress of the Australian College of Mental Health Nurses, might help you to better understand the consumer perspective.

Box 2.2 continued

power, her own resourcefulness. Mary’s experience of care within mental health services was one of being ‘skilled in lowered expectations’; for example, repeatedly being told that things such as studying or working would be too stressful and she would not be able to do them. The way mental healthcare was provided to Mary encouraged passivity rather than autonomy. She found the capacity to tap into her own resourcefulness only by coming across the consumer/survivor literature that inspired her. She was then able to find and use her own power to get out of the cycle of madness. Mary went on to be appointed as a mental health commissioner in New Zealand and has been an international consultant on mental health since that time.

What was most difficult for Mary was not the symptoms but how people regarded her. In retrospect her madness was a place of beauty and difficulty, madness filled with soul. Mary talks about the terrible suffering and the desperate struggle of her madness, but she also talks about the richness in her experience that she could interpret as filled with purpose and meaning. She wanted acceptance of her reality. For Mary, the best thing people could have done was to be kind and accept her reality—a basic human response.


BRIEF HISTORY OF RECOVERY MOVEMENT AND RESEARCH

Historically, the consumer movement has championed recovery. Effective consumer groups began to emerge in the 1980s, yet people with ‘mental illness’ were pursuing their own goals back in the 17th century (Campbell 2009). The consumer movement grew out of the African-American civil rights movement and the rights movements for women, LGBTQI people and those with disability in the United States. At the same time in the 60s and 70s, hospitals in the United States were being closed. The civil rights of people who had ‘mental illness’ had long been denied and people became angry about a whole range of treatments they found abusive. Consumer groups banded together to advocate for significant change in mental health services and began to develop and run their own alternative models of care.

The consumer movement is at its heart a human rights movement, with a significant role in advocating for improved care and consideration of the needs of people with an experience of mental distress (Epstein & Olsen 1999). The Roots of Recovery (Davidson et al. 2010) provides an excellent resource for the history of recovery and explains why current concepts of recovery have emerged.

Simon Champ observed that the civil rights and the counterculture movements of the 1960s inspired new hopes for mental health professionals in how they could relate to their ‘patients’ and for their hopes for the person’s recovery. The impact of these changes, he states, is often ignored in the history of the consumer movement.

In addition, people who had been given a diagnosis and treated for a mental illness started to publish

Box 2.3 Link to personal stories

• The National Mental Health Commission’s A Contributing Life: The 2013 Report Card on Mental Health and Suicide Prevention has some interesting links to personal stories. The following link is to Grant’s story. Grant was a forensic mental health inpatient: www.mentalhealthcommission.gov.au/media/94357/07_Feeling_safe_stable_and_secure.pdf
and speak out about their experiences and to protest about the treatment they received and how services needed to change. These include Patricia Deegan (see www.patdeegan.com/pat-deegan/lectures/conspiracy-of-hope) and Judi Chamberlin (www.youtube.com/watch?v=FGT4xjXgmoE). Others (Lovejoy 1984 and Unzicker 1989) spoke about the importance of hope, acceptance, engagement in social life, active coping and reclaiming a positive sense of self as key factors they found helpful.

At the same time the anti-psychiatry movement, initiated by psychiatrist Thomas Szasz’s book The Myth of Mental Illness (1961), fuelled debate in the mental health field. Similarly, another psychiatrist, Franco Basaglia (Dell’Acqua 1995), was highly influential in changing Italy’s mental health institutions in the 1970s. He saw institutions as inhumane and worked tirelessly to bring people back into their community so they could reconnect with life. Basaglia (Babini 2014) was instrumental in the introduction of Law 180 in Italy that led to the closure of all mental health institutions. Ever since Trieste in Italy, where Basaglia worked, has been a role model for a significant number of countries wanting to transform their mental health services.

The concept of recovery was cemented into services in 1993 when psychologist William Anthony coined the term the ‘decade of recovery’ and put forward a vision of recovery for mental health services. At the same time, researchers demonstrated that the course of illnesses such as schizophrenia was much more hopeful than had been previously accepted. As a result, recovery from mental illness could be talked about in a way that was supported by empirical research (Harding 1994; Warner 1994). In contrast to the previous doom and gloom message given to people about how they would be on medication forever and live a life defined by disability, it was found that 65% of people actually recovered fully (no symptoms), lived independently and no longer needed medication. Further, many of these people had been institutionalised for up to 30 years.

Critical thinking challenge 2.1

Access the following link and listen to the webcast: http://cpr.bu.edu/resources/webcast/recovery-vision. What are the important factors that stand out for you in terms of understanding people’s journey of recovery and what this means for your practice?

Qualitative research into recovery began to appear in the late 1990s. These researchers (Tooth et al. 1997; Tooth et al. 2003; Adame & Knudson 2007; Borg 2007; May 2010; Onken et al. 2002; Ralph 2000; Ridgeway 2001; Sells et al. 2006) believed it critical that people with a lived experience of mental distress were best placed to identify those factors that are important to their recovery. They found the important factors to be: the individual’s personal characteristics (the most important factor in aiding recovery); supportive others; natural supports in the community; and those professionals who listened to them as ‘equals’. Drawing on these findings, consumers identified the following as the most important factors in their recovery:

- having self-determination
- discovering a more active sense of self (personal agency)
- valuing themselves as a person through their interactions with others
- realising the need to help themselves and to take responsibility for their distress
- seeing the potential for richer identities other than that of a person with mental illness
- reflecting on positive experiences leading to consideration of other potentials
- exploring experiences with reference to both the present and the future self
- finding ways to monitor and manage the symptoms of distress
- tapping into their own inner wisdom
- having optimism
- recognising the importance of spirituality.

Please note that whilst recovery is the current context within Australian mental health services, internationally consumers who are the driving force behind recovery have advanced beyond recovery to focus on wellbeing (Ning 2010). Here, recovery is the process and wellbeing is the goal. This ongoing dynamic movement in conceptualisation of recovery is demonstrative of the rapidly changing focus in mental health mentioned at the beginning of this chapter.

**RECOVERY-INFORMED PRACTICE**

The recovery paradigm provides us with challenges in how we give priority to the person’s meaning of their experiences and use our knowledge so that consumers feel understood, heard and empowered from their perspective. Policies require this of us, yet it is proving difficult to put into practice (Slade et al. 2014). The aim of this section is to assist the nurse to clarify and give examples of recovery-informed practice. Many of the concepts and principles of recovery are intertwined. To focus on one at the exclusion of others is meaningless; they are all necessary. So how does recovery-informed practice differ from past mental health practices that were primarily medically focused? The following section addresses some of these issues. See Table 2.1 and Nurse’s Story 2.1, which illustrate the need for recovery-informed practice in a number of areas.
Table 2.1 Key differences between recovery-informed and traditional practice

<table>
<thead>
<tr>
<th>RECOVERY-INFORMED PRACTICE</th>
<th>TRADITIONAL PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Person is central</td>
<td>• Illness and symptoms are central</td>
</tr>
<tr>
<td>• Driven by human rights agenda</td>
<td>• Driven by the medical model</td>
</tr>
<tr>
<td>• Connecting with and maintaining meaningful roles, relationships and community is key;</td>
<td>• Propensity for person’s life to revolve around and be</td>
</tr>
<tr>
<td>many things contribute to recovery</td>
<td>taken over by illness</td>
</tr>
<tr>
<td>• Looks for possibilities and promotes hope</td>
<td>• Looks for constraints and sets limits and lower expectations</td>
</tr>
<tr>
<td>• Collaborative risk management with the person</td>
<td>• Focuses on risk control by others</td>
</tr>
<tr>
<td>• Learns from people’s narratives of recovery</td>
<td>• Personal narratives not a focus of care</td>
</tr>
<tr>
<td>• The person has an expertise gained from their experience of mental health challenges</td>
<td>• Professional is the expert on the person’s experience</td>
</tr>
<tr>
<td>• Medication is a small part of management; types and doses titrated for the individual</td>
<td>• Treatment of symptoms, usually with medications the main form of intervention</td>
</tr>
<tr>
<td>• Person is the change agent</td>
<td>• The program is the change agent</td>
</tr>
<tr>
<td>• Takes a stance of ‘unknowing’ and curiosity to help uncover the meaning people make of</td>
<td>• Takes a stance of ‘knowing’ and looks for confirmation of symptoms to make a</td>
</tr>
<tr>
<td>their experience</td>
<td>diagnosis</td>
</tr>
<tr>
<td>• Empowering for the person to be acknowledged for their expertise</td>
<td>• Symptoms more important than personal meaning</td>
</tr>
<tr>
<td>• Promotes self-directed care requiring the active involvement of the person</td>
<td>• Promotes passivity and compliance</td>
</tr>
<tr>
<td>• Explores what is important to the person; recognises unique experience and takes</td>
<td>• Recovery primarily involves the active involvement of others</td>
</tr>
<tr>
<td>spirituality into account</td>
<td>• Informs people about illness and what is important to them to manage it;</td>
</tr>
<tr>
<td>• Connects with person’s strengths and draws on them to overcome challenges</td>
<td>spirituality not taken into account</td>
</tr>
<tr>
<td>• Choice and ability to connect with a broad range of services in community</td>
<td>• Focuses on deficits to treat and manage</td>
</tr>
<tr>
<td>• Peer support or peer run services are essential</td>
<td>• Choice of services can be limited</td>
</tr>
<tr>
<td>• Trauma-informed care—’what has happened to you’</td>
<td>• Peer support limited or non-existent</td>
</tr>
<tr>
<td>• Recovery is moving beyond premorbid functioning towards thriving and developing a</td>
<td>• Not trauma informed—background issue ‘what is wrong with you’ more important</td>
</tr>
<tr>
<td>a new sense of self</td>
<td></td>
</tr>
<tr>
<td>• Non-linear process</td>
<td></td>
</tr>
<tr>
<td>• Timeframes meaningless—ongoing process</td>
<td></td>
</tr>
<tr>
<td>• Crisis is a time of learning how to thrive; an active recovery space</td>
<td></td>
</tr>
<tr>
<td>• Recovery is, at best, returning to a premorbid level of functioning</td>
<td></td>
</tr>
<tr>
<td>• Linear process of interventions</td>
<td></td>
</tr>
<tr>
<td>• Recovery is the end point of the process</td>
<td></td>
</tr>
<tr>
<td>• Crisis is viewed as a relapse and failure</td>
<td></td>
</tr>
</tbody>
</table>

The most comprehensive work to identify principles of recovery-informed practice was undertaken by Le Boutillier et al. (2011). They sought to identify a conceptual framework for the key principles of recovery-informed practice from 30 documents in six countries (United States, England, Scotland, Republic of Ireland, Denmark and New Zealand). There were differences found across countries in document type and consumer involvement in their development. However, they were able to identify four practice domains.

1. **Promoting citizenship.** Citizenship is central to supporting recovery. It involves attending to the consumer’s rights, social inclusion and meaningful occupation.

2. **Organisational commitment.** Ensure the work environment and service structure are conducive to promoting recovery-oriented practice. This involves ensuring the organisational culture moves from a focus on services to focusing on the needs of the person. Recovery vision, workplace support structures, quality improvement, care pathway and workforce planning are included in this practice domain.

3. **Supporting personally defined recovery.** The heart of practice is supporting people to define their own needs, goals, dreams and plans for the future to shape the content of care. Individuality, informed choice, peer support, strengths focus and holistic approach are contained in this practice domain.

4. **Working relationships.** Therapeutic relationships are essential to supporting recovery and promoting hope. There must be genuine desire to support the person and their family.
Nurse's Story 2.1
A CASE FOR CHANGE

When two of the authors of this chapter began mental health nursing in the 1970s, which at the time was undertaken predominantly in large psychiatric institutions, our tasks were to observe people's signs and symptoms and document them in the person's file so that the extent of the deficits could be noted and treated by the psychiatrists. The basic aim was to alleviate symptoms, primarily through medication, so that people could return to their home environment. People often stayed within the institution for many years. During this time, the meaning and impact of these symptoms for the person were considered irrelevant. In fact, conversations along such lines were actively discouraged because it was believed that this would make the person's condition much worse.

One of the authors has a very vivid recollection of working in a 'back ward' (a ward for people with supposedly chronic and disabling illnesses requiring long-term care over many years) where one patient was described as having exhibited a fixed delusion since she was admitted at the age of 17. At the time she was 24 years old and the 'delusion' was still just as distressing: she believed that her stepfather was the devil. She would become highly distressed whenever he visited with her mother and the distress continued long after he left. The staff believed it was a delusion because they perceived the stepfather to be very caring and concerned about the woman's welfare. However, a young female doctor new to the ward decided to take up this woman's case because the delusion had not responded to medication. She went through the woman's file and found that no-one had actually talked to her about the content of the delusion (what it meant for her). When the doctor finally asked, the woman told her that her stepfather from a very young age had sexually abused her and that for her he represented the devil.

Although this is a dramatic example, it illustrates the need for practice that searches for the meaning of the experience for the person rather than practice limited to the observation of signs and symptoms. It also illustrates how people can become institutionalised.

In Australia, the National Framework for Recovery-oriented Mental Health Services: Policy and Theory (Commonwealth of Australia 2013a) identifies five practice domains and capabilities.

1. Promoting a culture and language of hope (overarching domain). Communicating positive expectations, promoting hope and optimism so the person feels valued, important, welcome and safe.
2. Person-first and holistic. Holistic and person centred, responsive to Aboriginal and Torres Strait Islander, immigrant and refugee backgrounds. Responsive to age, gender, culture, spirituality, LGBTQI people, families, carers and support people.
3. Supporting personal recovery. Promoting autonomy and self-determination focusing on strengths and personal responsibility while engaging in collaborative relationships and reflective practice.
4. Organisational commitment and workforce development. Recovery vision, commitment and culture, acknowledging, valuing and learning from lived experience with recovery promoting service partnerships with workforce development and planning.
5. Action on social inclusion and social determinants of health, mental health and wellbeing. Supporting social inclusion, advocacy on social determinants, challenging stigmatising attitudes and discrimination and developing partnerships with communities.

Translating recovery-informed practice into action

The transformation to recovery currently taking place in mental health services can be confusing and challenging for both experienced and beginning nurses. Recent research (Hungerford & Fox 2014) found consumers experienced mental health professionals taking a ‘hands off’ approach rather than working in partnership with the person. This may be due to uncertainty about what to do. Recovery’s focus on the person driving their recovery can also be mistakenly interpreted as totally keeping out of the person’s way.

The following section aims to address these issues by providing some basic suggestions to guide your practice. For more in-depth information you are encouraged to refer to A National Framework for Recovery-oriented Mental Health Services: Guide for Practitioners and Providers at www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovge. It is important as a nurse to keep in mind the political and social contexts that, in spite of the person’s, your and the service’s best efforts, may work against the person exercising their right to social inclusion, personal agency and self-determination (Clifton et al. 2012).

CITIZENSHIP

Citizenship is a basic human right. Citizenship has been a feature of mental health for more than 20 years. The concept of citizenship is founded in theory and research to support the full participation of persons who experience mental health challenges (Rowe 2015). In terms of practice, it is important to be aware of the factors involved in citizenship so the person’s rights are not invalidated. This is a societal issue that extends way
beyond mental health services practice but must be kept in mind. Rowe makes the following points to consider in relation to citizenship:

- Citizenship is based on the 5 Rs of rights, responsibilities, roles, resources and relationships.
- People must have a sense of belonging and relationships, with other members recognising them as valued members in society.
- It extends the concept of social inclusion, a part of citizenship, because a person can have social inclusion but not be treated as an equal member of society.
- People need to be able to do the things they like to do, are good at and value most so they can grow and learn.
- Citizenship involves social justice so there are no undue restraints or deprivations getting in their way or blocking them.
- For citizenship to occur, the socioeconomic, health, gender and cultural barriers need to be reduced and ultimately eliminated. This is particularly so for obtaining and maintaining meaningful work.
- To achieve citizenship requires advocacy and social change.

Maintaining people in employment as much as possible mitigates against their becoming dependent on mental health services (Davidson et al. 2010). Work is a very protective factor and every effort to keep the person in employment is paramount. People employed full-time are good at and value most so they can grow and learn. Those employed part-time fell in the middle, and those unemployed fell on the unhealthy end of all psychological and behavioural factors. There can be a number of factors that may impede a person's return to work and for this reason supported employment programs have been established.

SOCIAL INCLUSION

Social inclusion, while inherent in mental health policies and plans, remains poorly defined (Clifton et al. 2012). In their review of the international (English language) literature on social inclusion, exclusion and mental health, Wright and Stickley (2013) identify the relationship between exclusion, inequality and injustice. They note that the complexity of the concepts is tied up with significant socioeconomic and political issues. These authors suggest mental health clinicians should shift their focus from ‘doing activities’ to efforts that promote individual rights and access to supports that reduce health inequalities. The concept of social inclusion is also bound up with the opposite concept of social exclusion, this being the range of things that limit the capacity of individuals and includes stigma and discrimination, unemployment, low income, isolation, poor housing and lack of access to opportunities (Clifton et al. 2012).

KEEPING HOPE ALIVE

The National Framework for Recovery-oriented Mental Health Services promotes a culture of hope and optimism evidenced by the language used, and emphasises ensuring people feel valued, important, welcome and safe. To stress the importance of hope, research has found hope to correlate with wellbeing, quality of life, subjective satisfaction with life, spirituality, resilience, self esteem and self-confidence (van Gestel-Timmermans et al. 2010). In practice, this means communicating positive expectations and supporting the person in doing what they can to maintain hope.

Hope is an essential ingredient in recovery for Simon Champ, as outlined in his personal story in this chapter. He found that diagnoses, labels, being seen as an illness rather than a person and the loss of his identity all contributed to the loss of hope for some time. It was a struggle to regain it and Simon eventually found ways that worked for him to keep hope alive. Nowadays, we are much more attuned to keeping hope alive and it is imperative we keep hope alive for the person even if they have momentarily lost sight of it.

PERSONAL AGENCY

Davidson, Rakfeldt and Strauss (2010) argue that agency is the key to the transformation needed in recovery. They see an emphasis on activity, doing and occupation as core aspects of agency determining a person’s quality of life (p. 15). Personal agency is the fundamental freedom to fully participate in all aspects of life in the community with the full rights of all citizens. It is also being active in making meaning of one’s life and being an active agent by deciding to do particular activities (e.g. returning to work) or asserting one’s basic human rights (Lysaker & Leonhardt 2012).

Personal agency is internally motivated. Fundamental to personal agency is the belief in the ability to succeed. We know people are driven to act on things that are most important to them and give them pleasure. Their life evidences this in what they do and what they surround themselves with. When people experience mental health challenges, they may lose contact with these. Active involvement of the person in their care taps into and draws on their strengths, and promotes resilience, personal agency and their sense of overcoming adversities. Personal agency is a critical concept in recovery because it realises the importance of people actively contributing to their recovery to influence change.

How the nurse can promote personal agency

To ignite a person’s agency, start by being curious about what is most important to the person in their life. You could begin by asking who the person wants to be involved in their care, which family members and/or significant others they want to see, or do not want to see, and whether they want contact or support from particular people to provide some constancy in their lives.
An example of the latter occurred recently when one of the authors worked in an inpatient setting and facilitated the visits of a Pilates instructor for a woman who was receiving involuntary mental healthcare and had been given a diagnosis of bipolar disorder. This person felt that the ongoing contact with her Pilates instructor gave her a sense of continuing control over a small but very important part of her life despite her situation. Some considerations for promoting personal agency follow.

- Discover what gives most meaning to the person; for example, their passions, hobbies or work.
- For Simon Champ, one of the most important areas that drives his personal agency is visual arts. He states that he needs to immerse himself in the visual arts to function as a human being. This provides great insight into where he is most likely to become active and find meaning in his life.
- If you were assisting Simon Champ, you might be curious about why visual arts are important to him.
  - What specifically does he do in relation to visual arts?
  - When he is engaged in such activities, what does he get out of it?
  - How can he reconnect with the visual arts?
  - What can he do now or in the near future to engage further in the visual arts?
  - Identify what, if any, supports Simon could utilise to further engage with the visual arts.
  - Also sharing your connection with the visual arts builds a stronger rapport and relationship.

**SELF-DETERMINATION**

Self-determination is the basic human right to be able to make and participate in decisions about your life; having a choice in determining how you live your life; and having control over your life. These are fundamental tenets in all of the human rights declarations and conventions mentioned at the beginning of this chapter. The theory of self-determination is part of the recovery paradigm because of its centrality to a person’s recovery. Self-determination theory proposes the components of self-determination are autonomy, competence and relatedness (Sheldon 2012). These are required to effectively be able to participate in and make decisions and to have choice and control over one’s life. All people need these to grow and thrive (Sheldon 2012). Self-determination allows people to live a good life according to their own values and beliefs. What this looks like will vary among individuals and cultures.

The consumer movement’s motto ‘nothing about me without me’ reflects the above. This slogan had its roots in a South African disability movement (Leff et al. 1997). Maintaining and promoting a person’s right to self-determining is a fundamental principle of mental health services standards and legislation (Commonwealth of Australia 2013a, 2013b).

**How the nurse can promote self-determination**

Remember that when we interact with people during times of distress or challenge, we have a skewed view of their inherent capacities. Continually reflect on the assumptions you may be making about people to keep in check the capacity we all have to act ‘as if’ these assumptions are true. To protect and promote a person’s right to self-determine, you could consider the following.

- Maximise the person’s autonomy, their ability to self-regulate by taking control of and responsibility for what they do.
- Maximise the person’s capacity to make informed choices and make sure they are involved in decisions concerning them.
- Medications or other interventions may not be the person’s choice. Pat Deegan has attempted to address this by developing Common Ground. It is a tool for maximising a person’s autonomy and decision making within a treatment setting. Watch the short video at www.patdeegan.com/commonground.

**RELATIONSHIPS ARE CRITICAL**

Chapter 1 highlighted the need for awareness of a range of factors inherent in our relationship with others if we are to be effective nurses. We know relationships are fundamentally important from our earliest attachment experiences and throughout our life for our emotional, social and physical wellbeing. Yet, in mental health we have not been able to delineate those aspects of our relationships with the people with whom we work that are most important and effective (Browne et al. 2012).

Research on the outcomes of psychotherapy that are relevant to relationships in nursing has consistently found that the ‘non-specifics of psychotherapy’ (genuineness, empathy, warmth, positive regard, flexibility and the therapeutic alliance) are the most important in determining outcome (Arnow & Steidtmann 2014; Miller et al. 2014). Other outcomes studies (Cahill et al. 2013) report 15% of outcome effect is attributed to placebo, 15% to techniques of therapy, 30% to the therapeutic relationship and 40% to client specific factors. Such factors revolve around what the person does outside the therapeutic relationship, but also includes knowing what the person wants. When the therapeutic relationship and client factors were considered together, Cahill proposed the importance of the person’s point of view of what is helpful as being more important than what the nurse believes is helpful.

**What the nurse can do to develop the relationship**

To make sense of the importance of the relationship you develop with the person, reflect on a time when you or a family member had a significant health challenge. What were the most helpful factors in your or your
family member’s experience? What was the experience of a good nurse or health professional? Do you think this was about who the nurse or health professional was as a person and/or how they were able to uncover what was most important and helpful to you or your family member? What would be important to you if you needed mental healthcare? Chances are they are very similar to the number of factors consistently reported in the mental health literature cited above.

- During times when people are facing challenges it is important to come from a place of empathy not sympathy. Watch the YouTube clip at www.youtube.com/watch?v=1Evwgu369Jw.
- Watch the first 5½ minutes of the clip by Dr Amy Banks on understanding relationships: www.wcwoonline.org/Videos-by-WCW-Scholars-and-Trainers/forming-healthy-thriving-connections.

You will learn about developing your own helpful relationships as you gain experience. Continual reflection is critical to this process. Healthy relationships also require healthy environments. The internal environment of the people providing care and the culture of the health settings you work in are also important.

**TRAUMA-INFORMED CARE**

An essential component of a trauma-informed recovery-oriented approach is to practise within a framework that recognises that many people experiencing mental health challenges have a background of trauma. Significant research now demonstrates the clear links between trauma and the onset of a range of mental health problems (Atkinson 2013; Kezelman & Stavropoulos 2012; Slade & Longden 2015). (Also see Chapter 7.) This makes it imperative for nurses to be sensitive to the vulnerabilities and potential triggers that may give rise to re-traumatisation, and be aware that this could impede recovery. Advances in neuroscience provide critical information about trauma and how to approach our work with people in general.

You will know from your clinical education that the brain consists of three parts that develop from the bottom up. The parts talk to one another via trillions of neural pathways. The ‘primitive brain’ (the brain stem) is responsible for the automatic functions such as breathing, heart rate and survival. The ‘emotional brain’ (the limbic system) is responsible for emotions and memory; it is about survival and safety. The ‘thinking brain’ (the neo-cortex) is responsible for higher order tasks such as thinking, learning, decision making, reasoning, organising, planning, meaning making, gaining control over emotions and language.

When people experience trauma and/or severe emotional stress, it can be much harder to engage the thinking brain. Instead they ‘loop’ in the emotional brain and this builds stronger neural pathways, making it more likely they will experience distressing emotions in the future when challenges arise. The key here is the absolute necessity for people to feel safe so they can effectively engage with others in their ongoing care.

Consider when people come into care in an inpatient setting. Personal safety is an important basis for effective nursing care. Often, people will be frightened of the inpatient environment, including acute mental health units, particularly if it is their first experience of admission to a mental healthcare setting. You need to take time to find out how the person feels and what they need to feel safe and secure. It may be listening to them, or finding strategies that the person could use; for example, locking their bedroom door or calling for help if someone enters their room. Do not assume that the person experiencing mental distress will feel safe in the healthcare setting just because you feel comfortable in the environment as a nurse. Again, imagine the situation for yourself or a loved one coming into the same setting and you should be able to get a good sense of things that may be frightening.

People can experience trauma as a result of their contact with services and certain treatments. Over the past few decades, Simon Champ has written and spoken about the traumatising effects of symptoms, hospitalisation, solitary confinement and being torn away from his environment and connections with others who really cared about him (Champ 1998). He has heard from many people who have had similar experiences.

The essentials of trauma-informed care include recognition of the following (Atkinson 2013; Kezelman & Stavropoulos 2012).

- Complex trauma and its effects have been unrecognised in mental health systems. To counteract this, it is necessary to take a universal precaution approach that assumes that all people who seek mental healthcare may have experienced trauma.
- Services need to ensure early assessment of trauma history and supervision for staff in responding sensitively and appropriately to disclosures of trauma.
- Trauma survivors often feel a lack of safety in receiving services. Reiterating the necessity for the person to feel safe, nurses can respond by helping the person to lower their distressing emotions. For example: sitting, listening or walking with the person; using basic relaxation techniques; and ensuring a calm environment can all be important. When this occurs, they will be more likely to engage their thinking brain and find ways that work for them to feel safe.
- Impacts of trauma can affect how people react to potentially helpful relationships. Building trust is essential so you can work with the person. Remember, trauma often occurs when a person’s trust in people or situations has been severely violated. Nurses need to understand how trauma and abuse may have shaped difficulties in relationships and impact on therapeutic relationships.
Coercive interventions may re-traumatise people. Be mindful that nurses are often seen as figures of authority. Using the power that comes with this to exercise control over the person to do what you think they ‘should’ do will most likely be counterproductive, be seen as coercive and re-traumatise the person. Recognise the person’s strengths and support them to develop care plans that affirm their preferences for care and how they can manage distress.

Interventions that may be perceived as shaming and humiliating should be avoided. Nurses are responsible for maintaining the dignity and individual rights of the person at all times and providing services in ways that are flexible, individualised, culturally competent, respectful and based on best practice.

There is a strong need to focus on what happened to the person rather than pathologising the presenting symptoms. Nurses need to develop an understanding of presenting behaviour and symptoms in the context of past experiences.

Increasing understanding and skills in working within a framework of trauma-informed care is vital. Many resources are available as outlined in Box 2.4. Trauma-informed care is considered so important, there are increasingly more dedicated training programs being developed for people working in healthcare and welfare settings such as the free online training from the Australian Child and Adolescent Trauma, Loss and Grief Network at http://learn.earlytraumagrief.anu.edu.au. The Australian Childhood Foundation provides significant resources for those nurses working with young people at www.childhood.org.au/blog/home/2015/april/trauma-informed-care.

**Box 2.4 Trauma-informed care resources**

- Adults Surviving Child Abuse, www.asca.org.au

**Facilitating self-help and personal responsibility**

Past practices in mental health focused on the illness to the exclusion of the person experiencing the illness. Kalyanasundaram (2007) describes the process as follows: A person would go to a health professional for help. The professional would ask about ‘the problem’ (usually symptoms of illness), building a bigger and bigger picture of ‘the problem’. This would lead to the person focusing more and more on ‘the problem’. The problem would grow bigger and bigger and be added to by the person’s family or others asking about it. Soon the person’s identity would be taken over and consumed by IT—the problem, ‘the illness’. Further contact with mental health professionals would reinforce this by almost exclusively focusing on asking questions about IT. This is similar to the concept of problem saturation. Clearly, this scenario is unhelpful and disempowers the person.

**ASKING QUESTIONS AND SHARING**

Asking questions about the person and their experience, their strengths and how they have overcome adversity in the past promotes understanding and a sense of agency. It puts ‘the problem’ in context. The person does not become the illness, and retains a more robust sense of self. There is a tension between doing something for someone and encouraging people to care for themselves. There are times when fostering dependency by doing tasks for the person appears necessary, but in many cases it is counterproductive. The list in Box 2.5 describes the therapeutic use of questioning to promote self-help.

**Box 2.5 Therapeutic questions to promote self-help**

Examples of questions the nurse can ask:
- Can you help me to understand what the experience of . . . means for you?
- What are you most concerned about at the moment?
- Have there been other times in your life when you have had similar feelings?
- How did you overcome these difficulties in the past?
- What do you think you need now to help with your current situation?
- What do you know about yourself that will help you in your current situation?

The following link is a very good resource outlining the art and science of powerful questions. It does not pertain to mental health in particular and will be very useful for your future practice as a nurse: www.principals.ca/documents/powerful_questions_article%28World_Cafe_Website%29.pdf
Consumers can be key supports for many people in terms of self-help and taking responsibility. The sharing of experiences and stories of overcoming with others who have had similar experiences can be far more powerful than workers because people learn they are not alone, that there is hope and there are many different ways that may be helpful. Within Australia and New Zealand there are a considerable range of consumer organisations that provide advice, advocacy, support and service delivery. Some of the major national and state community managed organisations (CMOs) or non-government organisations (NGOs), focused on consumer and carer issues are listed in Box 2.6. Many other organisations providing broader supports operate at the local level throughout Australia and New Zealand. There are also a growing number of peer workers and peer run services emerging. These are addressed later in the chapter.

A number of alternative support groups have been established to support those consumers who hold firmly to their experiences, such as voice-hearing groups and to their experiences, such as voice-hearing groups and established to support those consumers who hold firmly addressed later in the chapter.

Focus on personal strengths

The importance of focusing on strengths has already been mentioned in this chapter. Here we deal with promoting people’s strengths in your practice in greater depth. Nurses are well placed to endorse the strengths-based approach (Xie 2013). Working with strengths was first used in education and is not a new concept. Educationalists found that focusing on a person’s deficit and trying to fix it was likely to make the person feel more anxious, blocked or even immobilised—the problem would often be exacerbated rather than alleviated. The inability of the person (and the professional) to solve the problem led to a sense of failure and a downward spiral was not uncommon. The strengths model proposes that all people have goals, talents and confidence, and that all environments contain resources, people and opportunities (Rapp & Goscha 2012). It supports Deegan’s (1988) assertion that people who have experienced mental distress are more interested in focusing on what they can do in order to move on with their lives and live as normally as possible within their community.

Focusing on strengths and personal values promotes a person’s resilience, aspirations, talents and uniqueness, focusing on what the person can do and how these strengths can be mobilised, and built on to overcome current difficulties. A key therapeutic practice is reframing from a pessimistic worldview to an optimistic one that instils hope and challenges self-stigma. For example, the nurse will want to know what the person has done in the past to overcome life’s difficulties and how they can use the strengths they used previously to overcome current challenges. Nurses are well placed to gently prompt people from taking a less positive view by asking about the exceptions; the times they do focus on what’s working and so on. It is critical here not to invalidate the person. Consider: ‘I appreciate that is how you feel’; ‘I wonder if there are times when things work for you?’

The nurse will also encourage the person to think of ways that will work for them. The nurse will not impose their own ideas but may offer suggestions, and will work with the person to explore and create options. The nurse will use the knowledge gained from a variety of sources to help in this exploration. The nurse works in partnership with the person—the nurse’s role is to reinforce the person’s plan and remind them of it if they do become unwell.

People overwhelmingly talk about the experience of mental distress as a transformative process where the old self is let go of and a new sense of self emerges (Deegan 2004). The intense struggle of dealing with mental health challenges leads to positive outcomes and a sense of personal agency that moves the person beyond where they would have been if they had not had the experience. Daniel Fisher, a psychiatrist with lived experience of psychiatric disability (his term), highlights the importance of a strengths focus: ‘I no longer search

**Box 2.6 Consumer organisations and useful websites**

- Mental Health Council of Australia (MHCA) is an independent peak national body for mental health: https://mhaustralia.org
- Sane Australia is a national charity helping people seriously affected by mental illness: www.sane.org
- Mental Illness Fellowship of Australia Inc., provides counselling and support and promotes awareness and research: www.mifa.org.au
- Association of Relatives and Friends of the Mentally Ill (ARAFMI) is a support group for families and friends: www.arafmi.org
- Te Puna Web Directory is a general directory of New Zealand and Pacific websites developed by the National Library of New Zealand/Te Puna Mātauranga o Aotearoa: http://tepuna.natlib.govt.nz
- Te Puni Kōkiri provides policy advice to government and other agencies and has links to other Māori-related websites, www.tpk.govt.nz
- The following websites contain information for the NZ and Pacific Islander Mental Health Workforce:  
  > Te Rau Matatini, www.matatini.co.nz  
  > Public Interest Advocacy Centre, www.piac.asn.au/project/mental-health-legal-services-project  
  > Judi Chamberlin, www.youtube.com/watch?v=FGT4xJXgmoE
for the sickness in myself or in those I grew up with as an explanation for my woes. Instead I search for the strengths in myself and those close to me which propel me through my version of the suffering we all share but seldom face’ (Fisher 1994, p. 1).

Nurse’s Story 2.2
MOVING FROM DEFICITS-BASED TO STRENGTHS-BASED PRACTICE

Sarah, a 22-year-old university student, was brought in for involuntary admission after having walked in front of traffic, unable to explain what had happened or to communicate what she was thinking or feeling. Sarah had a history of having been sexually assaulted the previous year and more recently had witnessed a woman falling in front of a train. She had also recently experienced sleeplessness and poor appetite, could not study and had great fears of herself and her family members dying. She had a very close and loving relationship with her parents and her twin brother.

Using principles of recovery-informed care, the nurse took considerable time to assist Sarah in establishing a sense of safety and control in the inpatient environment. This was achieved by allowing her family members to stay with her until she went to sleep. This involved the nurse negotiating for the hospital’s visiting policy to be interpreted more flexibly, as well as negotiating with other staff to spend as long with Sarah as she required to establish a sense of safety.

Sarah had difficulty talking directly with the nurse, but talking with family members in Sarah’s presence about their lives, their strengths as a family and how they had supported each other through difficult times was an approach that seemed to permit Sarah to calm herself and eventually she was able to communicate what her family could do to help her feel in control. She was able to make arrangements for the next day with her family and asked for her belongings to be brought in to the hospital and for friends to be contacted. Family members were able to tell stories of times they had overcome problems and the strengths they all brought to support each other.

Sarah’s admission was very brief and she reported having felt that the nurse and her family were encouraging of her in reminding her of the resources she had in her family and friends and how they were there to support her. She appreciated the time that the nurse took to patiently wait for her to be able to communicate.

The importance of reflection in relationship to recovery-informed practice

Reflection affects nurses’ individual understanding of a range of practice issues, increases awareness and clarifies aspects of themselves and their role. It involves being open to new challenges and seeking new opportunities. This very much reflects the nurse’s capacity and willingness to be open to change in attitude and thinking.

Within the emerging recovery paradigm, a significant amount of learning is gained from our interactions and relationships with people who have the lived experience of mental distress. Mental health professionals have much to learn from them about the nature of mental distress and the most important factors in helping them to get on with their lives in a way that is meaningful to them. We also learn about how we help and frequently hinder, their self-directed recovery. Reflection, critical thinking and analysis are essential skills enabling all those involved in mental healthcare to evaluate and incorporate evolving knowledge into their practice. Reflection was dealt with in more detail in Chapter 1.

On the importance of reflection in nursing practice, we want to raise an issue that has not been satisfactorily addressed in the nursing profession. Specifically, what happens when a nurse has or develops mental health challenges? In the context of practice this is of critical importance, and discussion and debate on the topic are long overdue. Refer to Nurse’s Story 2.3 by Vicki Stanton.

EXTERNAL ENVIRONMENTS THAT FACILITATE RECOVERY

We have discussed what is important to personal recovery, or the internal environments of individuals. There are numerous external environments that support the person’s recovery efforts including the person’s immediate family, significant others and friends; relationships and supports in the person’s natural community through to the wider community with its range of options for people to develop valued social roles. People spend only a fraction of their lives in contact with services; the majority of their lives is spent in the community.

The concepts of recovery, social inclusion, self-agency and citizenship stress the importance of external environments for people to live full and meaningful lives. This section looks at what is required in the external environments and, as mentioned earlier, there is ample knowledge in this area from the many consumers who have published seminal works about their stories of recovery and experiences of care (e.g. Deegan 1988; Lovejoy 1984; Unzicker 1989). These stories indicate that recovery can occur without the involvement of mental
Nurse’s Story 2.3
MY EXPERIENCE AS A NURSE WITH MENTAL HEALTH PROBLEMS: VICKI STANTON

As a very experienced mental health nurse, I was able to recognise my own spiral into profound anxiety and depression when it started, but my senior position within the mental health service I was working in made it difficult for me to reach out to colleagues for support. I had been a highly functioning mental health worker for my entire career, never entertaining the idea that I would need to see a psychiatrist and take medication over many years. My early life experience of traumatic loss of my child when I was very young had been firmly buried I thought, locked in a vault, never dealt with, until events conspired to crack the vault and I unravelled. My years of strength and resilience following trauma gave way, and I couldn’t self-correct and felt completely unable to talk with my colleagues about my mental health needs. The experience also raised some important issues about whether I could continue working as a nurse.

How did my experience of mental illness impact on my ongoing work as a nurse?
When I first became acutely unwell my work involved significant responsibilities in a very senior mental health management position. Commencing medication and feeling acute distress impacted on all areas of my functioning. Medication was a double-edged sword, necessary, but side effects were distressing and impacted on my ability to function. Initially, I took considerable sick leave and negotiated lighter duties. I had to search for mental healthcare that did not involve workers who I knew in my day-to-day work, to ensure confidentiality was maintained. When I did return to work, with the workload changes, I realised that I needed to resign from the high-pressure job I had been in for decades. A significant reason for resigning was the extreme hesitation I felt, and my colleagues in the mental health service also experienced, in having any discussion about my needs as a mental health worker with mental health problems. It was like dancing around an insurmountable issue, and this change in the relationship with my colleagues negatively impacted on my identity.

After resigning, I relocated back to the city to engage long term with a psychiatrist. In the city I could do this with complete confidentiality. I took some more leave, and explored options for part-time and casual work. This gave me the flexibility to adjust work depending on how I was coping.

How did I manage working in an acute clinical setting?
Seeing a private psychiatrist regularly was an important part of ensuring I did not compromise my nursing practice. I also engaged in ongoing supervision, including with both a peer credentialled mental health nurse and a senior MHS psychiatrist. I routinely discussed my clinical work in the acute mental health setting and with asylum seekers to ensure my nursing practice was safe.

How could I discuss this with my colleagues?
This was a great source of stress during four years of mental health treatment. It created anxiety that my colleagues might find out that I was regularly seeing a psychiatrist and taking medication. I feared them viewing me as less competent, less trustworthy or scrutinising me for signs that I was not functioning. While it wasn’t likely that colleagues would know unless I told them, for many years the feeling of having to hide this part of myself was difficult.

There were times when I wanted to talk with colleagues based on something I’d experienced, and could recognise in people we were working with, such as discontinuation symptoms or other symptoms. In hindsight I believe both my colleagues and I could have benefited from my insights. However, I haven’t talked with colleagues to date because I don’t feel that nursing has yet come to terms with mental illness within the nursing profession. The fact that we don’t discuss it means we don’t take advantage of the richness of experience and perspectives of nurses who have recovered from mental illness and gone on to weave these experiences into our practice. Having a dialogue about this may assist nurses in the future to feel that they can engage in recovery and continue as nurses.

What was most helpful to personal recovery?
The things that were important to me in my recovery were the same things that are the theme of this chapter: connectedness, belonging, making sense of my experience and integrating this into my identity as a nurse to reclaim my strength.
health professionals and, unfortunately, in spite of them in some cases.

Remember that mental health services play only a small but important role in the person’s overall recovery journey. The community of which the person is a member provides a wealth of resources that are essential to all people, inclusive of those people experiencing mental distress. Nurses now need to be able to extend far beyond their previous traditional roles in their ability and creativity to find and use the resources available in the person’s community. This section briefly discusses community-based mental health services and community-managed organisations (CMOs).

Mary O’Hagan (2011) outlines alternative ways the healthcare system can respond, such as creating an optimistic culture, environment and expectations, and shifting the focus to self-determination, personal power and resourcefulness rather than focusing on symptoms and functional limitations. While individuals may have distress that interferes with their functioning at a particular point in time, this does not mean they will not benefit from engaging in activities of everyday life. As stated earlier, there is evidence that engagement in work and other meaningful pursuits leads to a diminishing of mental distress and promotion of general wellbeing.

Supportive environments are also termed enabling environments in recognition of the fact that we have been wrong in assuming that our system environments are inherently helpful. Some environments, including those of government and non-government services, do not in and of themselves enable people to move towards recovery. Johnson and Haigh (2011) outline the core elements of enabling environments as follows:

• The nature and quality of relationships are highly valued.
• Responsibility is shared by all participants.
• Everyone’s contribution has equal value.
• There are opportunities for creativity and initiative.
• Decision making is transparent.
• Power and authority are open for discussion.
• Behaviour is seen as meaningful and a communication to be understood.

RECOVERY-INFORMED SERVICE PROVISION

The policy frameworks of the Commonwealth and State governments guide recovery-informed service provision. Chapter 4 deals with these in greater detail. The Council of Australian Governments (COAG) endorsed the Commonwealth Government’s Roadmap for National Mental Health Reform 2012–2022 (2012). The Roadmap highlighted the following priority areas:

• person-centred approaches
• improve the mental health and social and emotional wellbeing of all Australians
• prevent mental illness
• focus on early detection and intervention
• improve access to high-quality services and supports
• improve the social and economic participation of people with mental illness.

The Roadmap focuses on the need for social inclusion for people with mental illness through a broad range of support services that will facilitate recovery, including: increased access to education, employment and training; stable and affordable housing; community resources; and the ability to influence decisions that affect them.

The New Zealand document Like Minds, Like Mine: National Plan 2014–2019 describes a program to promote the wellbeing, human rights and social inclusion for people experiencing mental disorder. Social inclusion in the NZ Like Minds, Like Mine document is outlined as follows.

Social inclusion means that people with mental illness are able to participate in the community as employees, students, volunteers, carers, parents, etc. They have a personal identity, aside from ill health, and have valuable contributions to make within the many communities to which they belong (Ministry of Health and Health Promotion Agency 2014, p. 4).

The mental health service

Within mental health services, there are a number of settings in which a nurse may practise (see Chapter 23). The most common of these include inpatient services in general hospitals, crisis teams, community mental health teams and recovery-focused services. Community-based settings are where the majority of people receive services and nursing practice in these settings will include the following aims:

• assisting the person to access the services they need and want
• promoting the person’s inner resources
• actively supporting the person to achieve their self-defined goals
• promoting the person’s engagement in fulfilling activities of their choice
• advocating for the upholding of the person’s rights
• assisting the person to advocate on their own behalf
• facilitating access to the people, places and things the person needs to survive (e.g. shelter, meals, healthcare)
• promoting a healthy lifestyle
• assisting the person to alleviate distress and identify helpful strategies
• working with the person to ensure their own safety and that of others.

The focus of practice in the various settings will be determined by the person’s needs, which will change over time. Nurse’s Story 2.4 illustrates how community mental health nurses can provide a range of supports for people to achieve outcomes that are not possible in hospital.

Nurses must be aware that the community setting has the potential to be a site where mental healthcare
Nurse’s Story 2.4
WHAT NURSING CAN ACHIEVE IN THE COMMUNITY

Johanna, a 26-year-old woman, had recently emigrated from Armenia with her husband Frank and six-month-old son. Johanna was experiencing her second episode of major depression with psychotic features. Her previous psychiatric treatment prior to coming to Australia had been entirely hospital based, and when community care was suggested for this second episode of depression, Frank was reluctant to take any risks until Johanna was completely well. Frank was at work during the day, they had no family or friends in Australia, and he could not take leave to care for Johanna. Therefore, he felt she would be safer remaining in hospital. Johanna was afraid that if she stayed in hospital as long as she did on her previous admission, she would not bond with her son. Frank was persuaded to support the option of community care when reassured that resources were available to provide support during the day. Family care workers were identified who were available to provide support in their home during the day. A small network of women from Armenia who met at the local migrant resource centre also provided much-needed social support.

Within the recovery framework the important elements in responding to Johanna included identifying her strengths in her existing relationships with family and community and emphasising these. The nurse used curious questioning to help Johanna get in touch with ways she could manage her distress and work through her fears about being in control with her son and her family life. Johanna reported that this episode of depression was not as prolonged as her previous one where she was hospitalised. She felt less isolated, more in contact with her family and other people, and wanted to get better because she was encouraged by the normal day-to-day activity around her. Johanna felt confident that with the support of the people around her she could explore her distress and learn how to manage the challenges it presented her with.

Nurse’s Story 2.5
RECOVERY-INFORMED PRACTICE WITHIN AN INDIGENOUS SETTING

Nurses working in the mental health service in Alice Springs and the surrounding region are continually challenged to provide recovery-informed mental healthcare to Indigenous people in ways that have meaning within the cultural context—a very different context to the professional backgrounds and knowledge bases of the majority of mental health workers in the area. Indigenous people comprise approximately half of all admissions to the service. Routine practices now include the encouragement of traditional Indigenous practices alongside Western medicine. Mental health nurses provide Western treatment and counselling alongside, and informed by, Indigenous traditional healers when the family indicates that this is necessary for the wellbeing of the person. The traditional healer, or Ngangkari, is considered a crucial part of the care provided to address the cultural and spiritual issues for Indigenous people receiving mental healthcare in Central Australia. The meaning of the episode of mental distress as identified by the individual, their family and the traditional healer is considered paramount.

Community-managed organisations

Community-managed organisations (CMOs), otherwise known as non-government organisations (NGOs), have increasingly been playing a key role in the provision of support to consumers and carers affected by mental distress through direct service delivery. They complement existing mental health services and strengthen community supports and partnerships. The main service types of CMOs include accommodation support and outreach; employment and education; leisure and recreation; family and carer support; self-help and peer support; helpline and counselling services; and promotion, information and advocacy.

The nurse’s role is to increase their knowledge of these aspects of CMOs:

- The range of community managed organisations in the community that promote social inclusion, and how to work collaboratively with all services that are necessary to meet the needs of people experiencing mental distress. The last decade in particular has seen a massive expansion in the range and number of support programs provided through a diverse number of agencies.

is experienced as disempowering and stigmatising. Light et al. (2014) describe the experience of people subject to community treatment orders in Australia, highlighting the concerns that while receiving such care, these consumers and carers continued to experience isolation, loss and trauma, vulnerability and distress, and disempowerment. The consumers and carers in the study by Light et al. (2014) described community treatment orders as both providing access to services, but at the same time reporting that the access was to a restricted form of service dominated by medication and
The principles of working in ways that promote self-agency. A good overview of these principles can be found in the National Framework for Recovery-Oriented Mental Health Services at www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc

Further information on the range of supports provided by CMOs can be found at the website of the Mental Health Coordinating Council, one of the peak organisations in Australia (www.mhcc.org.au). The Mental Health Foundation of New Zealand is a charity dedicated to working towards ‘creating a society free from discrimination, where all people enjoy positive mental health and wellbeing’. Its website provides numerous resources including the support services available and outlines of their programs (www.mentalhealth.org.nz). See also the New Zealand Mental Health Advocacy Coalition’s discussion paper Future Responses to Mental Distress and Loss of Well-being at www.mentalhealth.org.nz/assets/Our-Work/Destination-Recovery-FINAL-low-res.pdf. This is an excellent resource on New Zealand’s view of future mental health services.

While it is critical to work in an integrated way with CMOs and other providers, it is essential to remember that CMOs are not whole-of-life services, but rather stepping stones for those people who choose to use them. The aim is for people to develop naturally occurring supports within the community or to use other created supports that are accessed by all members of the community.

Peer support workers in mental health

Peer support refers to the provision of support to people with mental health challenges by people who have also experienced challenges with their mental health. There are many titles describing these roles, including peer support workers (PSWs), consumer workers, peer educators and peer specialists. The essence of these various roles is to provide support based on mutual respect, shared responsibility and mutual agreement about what support is needed (Repper & Carter 2011).

The value of peer support includes: the reciprocity between people who both have a lived experience that is not a part of the exchange with non-peer workers; the aspiration that comes from working with someone who has achieved personal growth; more equality in interactions; and the capacity for people using services to maintain self-agency in these more equal relationships (Austin et al. 2014). Repper and Carter (2011) found that peer workers were able to foster those aspects of recovery such as hope, empowerment and self-efficacy that are integral to self-agency. Slade (2009) writes of the benefits of peer support workers as including:
- the benefits to the workers themselves of being employed and valued for their experience
- the value to non-peer mental health workers of seeing peer workers in their roles in ways that can highlight the values and raise awareness of the values inherent in their roles
- the benefits to people with mental health challenges seeing peer workers as positive role models
- the role of peer workers as culture carriers to shape change within mental health services.

The National Mental Health Commission’s 2013 report A Contributing Life, the 2013 report card on mental health and suicide prevention, recommends that the peer workforce is considered essential as a component to all mental health support teams, and recommends the development of a National Mental Health Peer Workforce Development Framework, as well as targets for peer support workers into the future.

In addition to peer workers within mental health services, there are growing numbers of peer-provided services. One example is the voice-hearing network that runs regular groups specifically for voice hearers. They are very successful for those who attend and facilitate their recovery (de Jager et al. 2015). The voice-hearing network now runs international conferences. Information about a variety of peer services can be found in Box 2.7.

**Box 2.7 Information about peer workers and peer services**

- The following links provide further information on peer support:
  > PeerZone, www.peerzone.info
  > Hearing Voices Network Australia, http://hvna.net.au
  > Hearing Voices Network Aotearoa NZ, www.hearingvoices.org.nz
  > Rufus May is highly regarded in the voice-hearing network and mental health. He has two videos on his website that are recommended viewing: www.rufusmay.com
  > Far North Queensland Partners in Recovery has a number of great resources on a range of topics: www.fnqpartnersinrecovery.com.au/blog/wp-content/uploads/2015/04/the-art-of-powerful-questions.pdf
  > Intentional Peer Support is an organisation established in the 1990s by Shery Mead, one of the founders of peer support in the United States: www.intentionalpeersupport.org/about-us
CONCLUSION

Mental distress is a part of human existence: it varies in degree, but it may happen to all of us. The journey of healing and recovery is salient for everyone. There is a need to talk about recovery in more humane terms, because it is not something that happens to ‘the other’: we are all vulnerable to mental distress under certain circumstances. Nurses need to be with people in this humane context rather than in a context of pathology, difference and a reductionist focus on symptoms and diagnosis.

We encourage you to reflect on how the principles of mental health practice are fundamental to all nursing practice, regardless of setting. We hope we have encouraged you to think about how you can participate more fully in your practice by developing your awareness of the complexities and realities of the context in which practice occurs. More specifically, we hope you appreciate how your attitudes, values and beliefs play a crucial role in your everyday practice.

Mental health nursing practice is also influenced by an ever-evolving knowledge base; hence, the principles informed by this knowledge base continue to change and to evolve. Practice is time and context specific, making the ability to tolerate and incorporate change vital. Consequently, your thinking about your practice will be continually influenced by your developing self-awareness, your incorporation of new ideas into your practice, and your increasing professional and personal experience.

The primary focus of mental health nursing practice is the consumer, and how nurses can help facilitate the consumer’s recovery. Nurses can assist in this process by working in partnership with consumers to help them realise their potential and tap into a wide range of community resources and supports, of which mental health services are just one. Just as importantly, we hope you find the experience of mental health nursing as rewarding as we have.

Exercises for class engagement

Imagine yourself in the scenarios below and, in groups, answer the questions that follow.

Scenario 1
You have been hospitalised with an acute medical condition. Medical advice is that you have diabetes. You are being given instructions for self-management of insulin injections and monitoring of blood sugar levels before discharge from hospital.

Scenario 2
You have been hospitalised after an acute episode of depression. Medical advice is that there is a high likelihood that you have bipolar depression. You are being given instructions on the possible side effects of the antidepressant medication you have been prescribed and are advised that you will have to continue taking some form of medication indefinitely.

Questions
In groups of four or five, discuss your thoughts and feelings about the above scenarios. Use the following questions as discussion points. Note any similarities and differences in opinion among group members as well as between the two scenarios.

• What are your immediate concerns?
• What information would you seek?
• What type of support would you wish to receive, and from whom?
• What would be the most important knowledge and skills for nurses in the different care units?
• What could your nurse do that would be helpful or unhelpful?
• What do you think will be important considerations for the rest of your life?
• Do you think you should take an active role in your present and future care? If so, how could this best be achieved?

Scenario 3
Emily is 36 years old and married to Grant, with whom she has two sons aged five and seven. They have recently moved to a regional centre and have no family support. Emily is currently experiencing her second episode of bipolar disorder and is in the hypomanic phase of her illness. Grant is very concerned about Emily’s ability to be an effective parent, but he also has longer term fears about their relationship.

Question: How could the principles of recovery-informed practice be used to assist Emily? Focus on aspects of the client’s recovery rather than symptom management.
References

Adame AL, Knudson RM 2007 Beyond the counter narrative: exploring alternate narratives of recovery from the psychiatric survivors movement. Narrative Inquiry 17(2):157–78

Anthony WA 1993 Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal 16(4): 11–23

Arnow BA, Steidtmann D 2014 Harnessing the potential of the therapeutic alliance. World Psychiatry 13(3):238–40


Borg M 2007 The nature of recovery as lived in everyday life: perspectives of individuals recovering from severe mental health problems. PhD thesis, Norwegian University of Science and Technology


Champ S 1998 A most precious thread. Australian and New Zealand Journal of Mental Health Nursing 7(2):54–9


Davidson L, Rakfeldt J, Strauss J 2010 The roots of the recovery movement in psychiatry. John Wiley and Sons, West Sussex


Deegan PE 1993 Recovering our sense of value after being labelled mentally ill. Journal of Psychosocial Nursing 31(4):7–11

Deegan PE 2004 Rethinking rehabilitation: freedom. 20th World Congress of Rehabilitation International. Oslo, Norway


Deveson A 1991 Spinning Out: A documentary special on Schizophrenia. Ann Deveson Productions & the Australian Film Finance Corporation, Australia


Hungerford C Fox C 2014 Consumer’s perceptions of recovery-oriented mental health services: an Australian case-study analysis. Nursing and Health Sciences 16:209–15


Kalyanasundaram V 2007 Facilitating recovery oriented practice. Workshop notes, NSW Institute of Psychiatry, Sydney, 22–24 August


May R 2010 Facilitating recovery workshop. NSW Institute of Psychiatry, Parramatta, April

McLean R 2005 Recovered not cured: A journey through schizophrenia. Allen & Unwin, Sydney

Mental Health ‘Recovery’ Study Working Group 2009 Mental health ‘recovery’: users and refusers. Wellesley Institute, Toronto


Morrow M 2011 Recovery: progressive paradigm or neoliberalism. Paper presented at Beyond access: from disability rights to disability justice. Society for Disability Studies, San Jose, CA

Ning L 2010 Building a ‘user driven’ mental health system. Advances in Mental Health 9(2):112–15

O’Hagan M 2011 Recovery-based services: the four pillars. Inside Out seminar, Parramatta, 10 March

Onken SJ, Dumont JM, Ridgeway P, Dorman DH, Ralph RO 2002 Mental health recovery: what helps and what hinders? National Technical Assistance Center for State Mental Health Planning (NTAC), National Association for State Mental Health Program Directors (NASMHPD), Alexandria, VA

Ralph RO 2000 Review of recovery literature: a synthesis of a sample of recovery literature. National Technical Assistance Center for State Mental Health Planning (NTAC), National Association for State Mental Health Program Directors (NASMHPD), Alexandria, VA


Slade M 2009 100 ways to support recovery: a guide for mental health professionals, Rethinking recovery series 2009 volume 1, Rethink, London.
Slade M, Longden E 2015 The empirical evidence about mental health recovery: how likely, how long, what helps? MI Fellowship, Victoria
Tooth B, Kalyanasundaram V, Glover H, Momenzadah S 2003 Factors consumers identify as important to recovery from schizophrenia. Australasian Psychiatry 11(1):70–77
Xie H 2013 Strengths-based approach for mental health recovery. Iran Journal of Psychiatry and Behavioural Sciences 7(2):5–10

Useful websites
Adults Surviving Child Abuse, www.asca.org.au
Association of Relatives and Friends of the Mentally Ill (ARAFMI) is a support group for families and friends: www.arafmi.org
Far North Queensland Partners in Recovery has a number of great resources on a range of topics: www.fnqpartnersinrecovery.com.au/blog/wp-content/uploads/2015/04/the-art-of-powerful-questions.pdf
Hearing Voices Network Aotearoa NZ, www.hearingvoices.org.nz
Hearing Voices Network Australia, hvna.net.au
Intentional Peer Support is an organisation established in the 1990s by Shery Mead, one of the founders of peer support in the United States: www.intentionalpeersupport.org/about-us
Judi Chamberlin, www.youtube.com/watch?v=FGT4xXjXgmoE
Mental Health Australia (an independent peak national body for mental health that has a wide range of important resources), www.mhca.org.au
Mental Health Council of Australia (MHCA) is an independent peak national body for mental health: https://mhaustralia.org/
Mental Health Recovery Services: The Richmond Fellowship: www.rfwa.org.au
Mental Illness Fellowship of Australia Inc. provides counselling and support and promotes awareness and research: www.mifa.org.au
National Mental Health Commission (numerous important resources), www.mentalhealthcommission.gov.au
NZ and Pacific Islander Mental Health Workforce:
• Te Rau Matatini, www.matatini.co.nz
• Le Va, www.leva.co.nz/mental-health-and-addiction
• Public Interest Advocacy Centre, www.piac.asn.au/project/mental-health-legal-services-project
Patricia Deegan, Recovery and the Conspiracy of Hope,
www.patdeegan.com/pat-deegan/lectures/conspiracy-of-hope
PeerZone, www.peerzone.info
Private Mental Health Consumer Carer Network
Rethink Mental Illness: Fill in the form to receive a free
copy of the guide “100 Ways to Support Recovery” at:
www.rethink.org/about-us/commissioning-us/100-ways-to-support-recovery
Rufus May is highly regarded in the voice-hearing network
and mental health. He has two videos on his website
that are recommended viewing: www.rufusmay.com
Sane Australia is a national charity helping people
seriously affected by mental illness: www.sane.org
Te Puna Web Directory is a general directory of New
Zealand and Pacific websites developed by the National
Library of New Zealand/Te Puna Matauranga o Aotearoa,
http://tepuna.natlib.govt.nz
Te Puni Kokiri provides policy advice to government and
other agencies and has links to other Maori-related
websites, www.tpk.govt.nz
Wellness Recovery Action Plan WRAP,
www.mentalhealthrecovery.com