‘Recovery’—the journey within three rural communities in New South Wales

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Abstract
The Benevolent Society is Australia’s oldest not for profit organisation and has been working with vulnerable people and communities for nearly 200 years. In 2008 we were successful in securing the Australian Government’s Personal Helpers and Mentors program (PHaMs) Armidale and in 2009 Inverell and Mudgee.

In general, the prevalence of mental health conditions in rural and remote Australia has been estimated as equivalent to levels in major cities. However, rural Australians face greater challenges as a result of such conditions, due both to the difficulty of accessing the support needed for mental illness and to the greater visibility and often stigma attached to mental health in a smaller community. Over the past two decades there has not been any real increase in spending to ensure the availability of the range of support services, clinical and non-clinical, needed by people with a mental illness to live well in the community. As a result, many people with a mental illness struggle to find proper care. This problem is accentuated if you live in a rural area which is likely to have fewer health professionals, and a much smaller choice of health service providers.

It is within this context TBS commenced its work in mental health, implementing the PHaMs program and developing a recovery orientated service. The PHaMs program intrinsically values the wisdom of those with a lived experience of mental illness and distress. The employment of peer workers and involvement of consumers in shaping service developments are key components of our work. The Australian Fourth National Mental Health Plan reflects the important shift in the field of mental health services, toward a recovery orientated approach. Recovery is a unique and personal journey that includes a sense of hope, wellbeing and autonomy. Our work recognises and builds on peoples’ strengths and resilience, and capacity for self determination.

The PHaMs service provides an opportunity for government and the non-government sector to work together to provide innovative assistance for people whose lives are affected by mental illness or distress. The aim of the PHaMs model is ‘to increase the opportunities for recovery for people whose lives are severely affected by mental illness’. This is underpinned by three secondary outcomes of increased: Access to appropriate support services at the right time; Personal capacity and self-reliance; and Community participation.

This presentation will highlight the unique difficulties and triumphs associated with the implementation of a community mental health program in a rural setting. It will identify the value of incorporating both peer support employment and consumer leadership. It will look at both qualitative and quantitative outcomes achieved by participants within the program, and the overall contribution the program is making to participants’ lives in both the New England and Central West areas of NSW.

Introduction

Mental health and wellbeing
This presentation will focus predominantly on the experience of the teams in the New England and Central West areas of NSW, who navigated the challenges of distance and found creative ways to support the development of Recovery-oriented practice in their work. Through the use of videoconferencing and a commitment to the Recovery Oriented Mentoring Project, colleagues supported and challenged themselves and each other to transform every aspect of the service to reflect the focus on Recovery Oriented practice as outlined in the Fourth National Mental Health Plan.
The Personal Helpers and Mentors program is an Australian Government Department of Families, Housing, Community Services and Indigenous Affairs funded program that supports people whose lives are affected by serious mental illness. A fundamental principle underpinning the program is the employment of workers with a lived experience of mental illness, this viewpoint brings a unique perspective and richness to the program.

One of the challenges of mental illness and distress within a rural and regional context is the impact of distance and isolation. As workers within these communities our experience of isolation can mirror that of the people who use our service. Recovery-oriented practice is a shift in the way mental health services approach service delivery and how society views those who experience mental illness or distress. The invitation to transform the way we look at the world and to look more deeply at the fundamental values that underpin our practice is a challenge The Benevolent Society has embraced across its metro and rural Personal Helpers and Mentors programs.

What is recovery?
The recovery movement can be traced to the United States in the 1970s and 1980s. This has heavily influenced the notion of recovery in policy and practice in other countries. Australia has embedded the notion of recovery into policy, but there is criticism that this has not yet translated into practice. Anna Schiff, a consumer and professional; described that:

“To me, being recovered means feeling at peace, being happy, feeling comfortable in the world and with others, and feeling hope for the future. It involves drawing on all my negative experiences to make me a better person. It means not being afraid of who I am and what I feel. It is about being able to take positive risks in life. It means not being afraid to live in the present. It is knowing and being able to be who I am.”

Recovery from mental illness is not the same as cure. It means regaining control over one’s life if not one’s illness. It means leading a useful, satisfying life even though symptoms may reoccur.

“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

Central elements described by people with a lived experience of a mental illness include the following:

- recovery is a unique and highly personalised experience
- recovery is an individually defined journey or process of growth and personal wellbeing—emotional, social and mental health
- recovery is non-linear, a process including ups and downs, periods of growth as well as setbacks
- recovery is a pathway informed by a person’s unique strengths, preferences, needs, experiences and cultural background
- relationships with family, friends, peers and practitioners can foster hope that in turn is a catalyst for recovery.

Implications for service implementation

Managing geographically dispersed staff
Establishing and delivering programs in rural NSW has presented The Benevolent Society with significant challenges. The establishment of PHaMs programs required remote management of staff new to the program and new to the organisation. We invested in technological solutions, which become the glue to alleviate the complications raised by dispersed teams. We invested in video-conferencing
technology to support increased effective communication and the development of a more cohesive and effective leadership and staff team. The beginning of the program implementation was critical for building relationships and trust and this was supported by establishing communication mediums that worked across programs.

**Learning and critical reflection**

One of the resilience principles underpinning our work states; “as we are all on a continuous learning journey, we take the time to think critically and reflect on our practice”. Once the programs were implemented, The Benevolent Society invested in developing the organisational understanding of recovery-oriented practice and critically reflecting on existing practice. In April 2011, all PHaMs staff, including managers, attended a 3-day workshop with Helen Glover at Enlightened Consultants and the appointment of Mental Health Practice Support Manager, Julie Miller to imbed recovery-oriented practice into all aspects of our service delivery. Again, we relied heavily on the use of VC equipment to enable consolidation and expansion of the learning gained at the training, and embarked on a 12 month “Recovery Oriented Mentoring Project” to deconstruct our current thinking and way of working and to co-construct a vision for Recovery-oriented practice across The Benevolent Society’s mental health programs.

**Recruitment of staff**

The workforce in partnership with consumers and carers, is at the heart of achieving a recovery-orientated service system. The development of recovery-orientated services emphasises the personal qualities of staff as much as formal qualifications.

Focusing on attitudes, behaviours, skills & knowledge supports a strong culture to develop workers’ capacity for Hope, Compassion and Acceptance. The importance of values and attitudes can not be underestimated. Recruiting staff who can align their personal values and attitudes with the organisation’s and behaviour that matches this, are more likely to be retained and support better outcomes for participants. There must be a strong belief by staff that every person who accesses a PHaMs program has the capacity to recover. Staff who genuinely believe this will be better able to ‘hold’ a participants’ hope, focus on their strengths and therefore provide better support.

**Peer support workers**

One of the unique aspects of the PHaMs program, is the requirement that at least one mental health peer support worker, a worker with a lived experience of mental illness and recovery, must be employed as part of the team.

Peer support programs have been at the cutting edge of exploring new practices. They are grounded in the knowledge that neither person is the expert, that mutually supportive relationships provide necessary connection, and that new contexts offer new ways of making meaning.

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful.

The peer support worker in this professional capacity becomes more than simply an acquaintance, the individual peer support worker is employed for the explicit reason that they themselves have their own experiences of having had a mental health condition which they are able to draw upon in a positive and educational way to help, assist and support others who themselves are commencing their own journey of recovery. Alongside this, peer workers demonstrate an alternative view to what is possible and are role models who challenge stigma and negative beliefs about the abilities and potential of those who experience mental illness. Developing a peer position description, allowed greater conversations and the investment of time to delve deeply into ‘what’ is a peer worker. This provided the organisation the opportunity to partner with Helen Glover, Director of Enlightened Consultants. The organisation initially did not see the commencement of PHaMs & peer workers as a ‘change process’. Dialogue with
Enlightened Consultants commenced ‘Recovery Oriented Mentor Projects’ (ROMPs) developing learning opportunities to more effectively embed recovery into practice. The Benevolent Society also employed independent consultant Mary O’Hagan to support peer workers and managers within the organisation to develop a deeper understanding of peer work.

Understanding peer work was a journey for the organisation and for the peer workers themselves. Peer workers sometimes faced similar stigma to that faced by those who access the PHaMs service, particularly for those peer workers who may have accessed local mental health services when unwell. This has proven to be an additional complexity for rural workers.

The Benevolent Society engaged Mary O’Hagan, an independent consultant with a lived experience of mental illness, to provide support and group supervision for peer workers across the organisation. This enabled a deeper understanding of the peer role and an ever-evolving understanding of how peer workers can be best supported and given opportunities to share their unique perspectives with the rest of the organisation.

Relationships with mental health services
It is generally acknowledged that most mental health services are currently organised to meet the goal of clinical recovery. In a recovery-oriented service, the focus is on self-efficacy and on dignity of risk alongside duty of care. People accessing the service are seen as experts of their own experience with the ability to make choices and be the authors of their own lives.

The PHaMs program is seen as a complementary program supporting other Commonwealth and State clinical and non-clinical programs. Ongoing feedback from community mental health sector stakeholders confirm the importance of community-based community-based programs in areas of prevention, early intervention and targeted support. Developing relationships with local clinical and community mental health services can pose challenges with differing views of recovery-oriented practice and a need for dialogue and a greater understanding of each other’s perspectives to support more effective care co-ordination for those accessing mental health services.

Staff attitudes
While recovery is not an intervention that staff can make, all services can contribute to the outcomes and experience of recovery, including well-being, self-esteem and empowerment. There are multiple barriers that people living with a mental illness may encounter from the service delivery level. Differing understanding of recovery; staff may have different ideas of recovery and may believe they are working in a recovery orientated way when that may not be the case. This may present as power imbalances between the staff and participants, where the staff assumes the role of the expert or the “rescuer”. Stigma and discrimination; staff can reinforce poor self-esteem of participants by judging their worth through the lens of their disability and treating people according to their symptoms rather than as a whole person. Duty of care, risk and coercion; manifesting as staff who are risk averse and err on the side of caution, discouraging participants from making decisions for themselves. A lack of a clearly articulated recovery orientated framework in services; that is creating outcomes based on a person’s unique and personal journey.

What worked
Strong leadership
The Benevolent Society leadership team developed and supported a culture of ensuring that the work environment and organisational culture were conducive to a recovery approach, this involved a commitment to continual learning both internally and externally and the embedding of recovery/resilience principles into practice. Inclusion of recovery principles in management processes, such as recruitment, professional development, supervision, staff appraisals, and service planning. The Benevolent Society developed the following Principles of Resilience:
1. We take a resilience-led approach to our work across the lifespan.

2. We respect people’s right to belong, live, love, work and play in their communities.

3. Our work invites people and communities to utilise their strengths and resources to go beyond merely coping with adversity.

4. Our work supports people to make connections with others, their families, and with their communities.

5. As we are all on a continuous learning journey, we take the time to think critically and reflect on our practice.

6. We hold ourselves and others accountable for maintaining high standards.

7. We believe that while professional support services, such as those provided by TBS, are part of the solution for people experiencing adversity, they are not the whole solution.

8. The aim of our work must be to give people independence and to leave them more connected and resourceful.

9. We work with and support people to take responsibility for their lives.

Practice support
The Benevolent Society created the position of Manager Practice Support for Mental Health in 2011. This position facilitated ongoing critical reflection and support for managers and staff in their work through practice forums, operational meetings, working parties, informal consultations and peer network meetings. This assisted the development of consistent practice and opportunities for ongoing challenging conversations and the learning journey of us all.

The recovery-oriented mentoring project and forums via video conferencing allowed a focus for each team on a particular project aiming to “transform service delivery” to share with other teams. This structure facilitated momentum for projects that invited greater consumer participation and leadership in the service transformation. A focus on how we shared our knowledge and understanding of recovery-oriented practice with participants accessing the service was transformative in itself. The idea of recovery-oriented practice as a social movement helped drive more meaningful conversations with participants about what “recovery” might mean for them. We focused on sharing our knowledge about Recovery-oriented practice and Resilience principles with participants who use our service (a) to ensure people made an informed choice about whether the program was right for them and (b) so that consumer participation in service development was meaningful. We also actively facilitated opportunities for participants to link with Consumer groups, such as the Consumer Advisory Group, when visiting local areas.

This move toward recovery-oriented practice was actually quite challenging for many participants who found the focus on greater self-efficacy and self-determination somewhat foreign. Many participants who enjoyed the sense of “safety” provided by service-based social groups struggled when these were altered. The concept of “tarago therapy”, where mental health “clients” are taken on social outings together were problematic. We struggled with the dependence on services and workers to create opportunities for connection, and the creation of “sheltered” spaces, away from the broader community, in order to have the basic need for community belonging and connection met. Staff as well as participants found this shift difficult. Groupwork within a recovery-oriented framework remains the topic of ongoing healthy and robust conversation.
Triumphs and challenges
The New England and Central West teams have faced many challenges and enjoyed many triumphs over the last 4 years. The suicide of participants, vicarious trauma, staff turn-over and the strain of travel on workers are challenges we all face in rural areas working in this field. Work Health and Safety can be an issue with poor mobile reception and long distances to travel and access to anonymous counselling support for staff where needed can be particularly difficult in smaller communities. The struggle of walking alongside people within our own community, confidentiality and privacy issues, child protection concerns within the families we work with and the complexities of personal connections linked to so many members of the community remains a challenge for rural staff. The suicide of participants and critical incidents rock the whole community, and can intensify the emotional stress of the work on staff and managers.

The triumphs are countless. Organisationally the triumph of imbedding recovery-oriented and developing structures to support its ongoing growth... for managers to be better able to understand and lead recovery-oriented practice and practice in line with the Resilience principles in supervision and service development... staff working in line with their values and having an impact on the negative stereotypes about people living with a mental illness... for participants to enjoy community art and gardening projects and connect to their own self-mastery and hope in their ability to be the authors of their own lives, participation in community events such as Relay for Life, or accessing volunteering, study and educational opportunities, participants realising they can achieve far more than anyone led them to believe or finding themselves in informal mentoring roles with others in a similar situation.

Perhaps the greatest triumph is the ongoing commitment to working in ways that break down stigma and facilitate social and personal change. The aim is always to create opportunities for people, including ourselves, to reconnect with potential and to embrace hope and possibility. We move from the place of experts in people’s lives to facilitators of different ways of thinking. We aim to ask more effective questions rather than provide the answers or the solutions and we acknowledge the wisdom every human brings to their life’s journey and honour each person as the expert of their own lives.

And we know that we are, indeed, on a continuous learning journey. We learn more about how to transform our work as we create more opportunities for those with a lived experience of mental illness and the people who use our service, to have a voice.

References