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DoH Framework for Recovery- Oriented Practice: A perspective from clinical mental health

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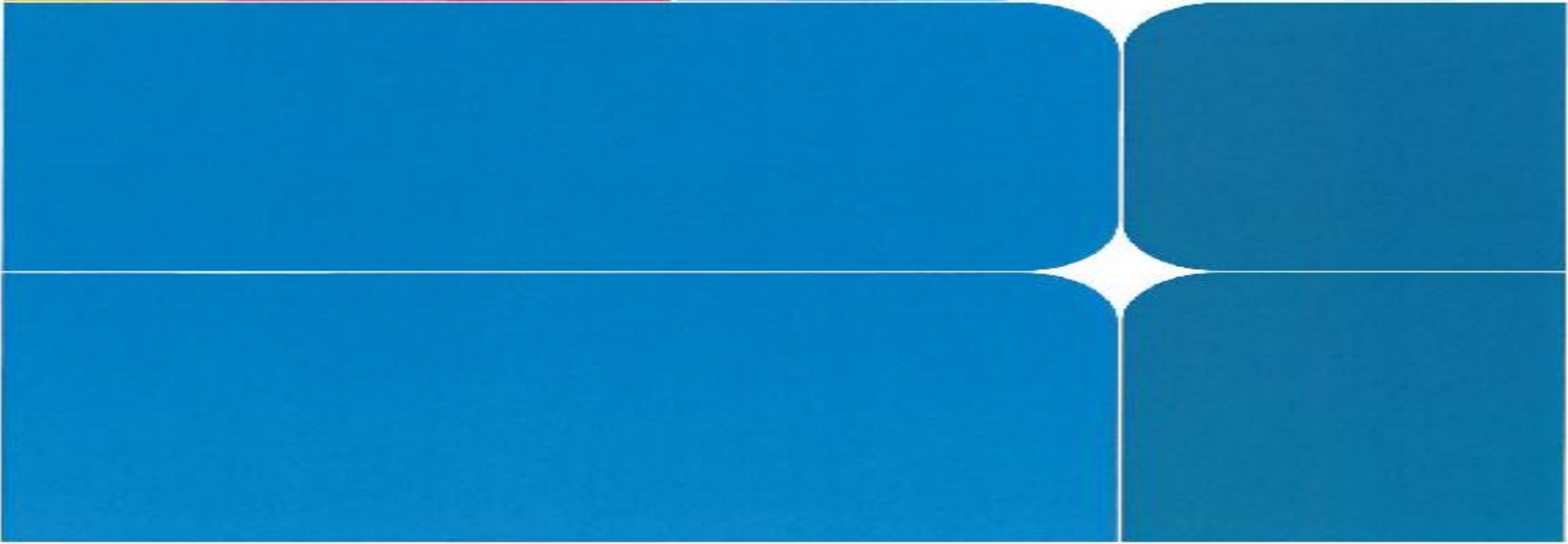
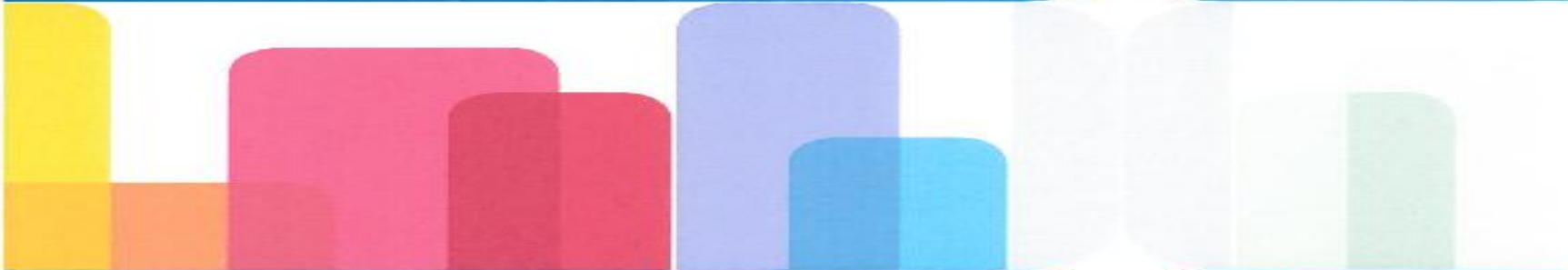


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Department of Health

health

Framework for recovery-oriented practice



DoH Framework for recovery-oriented practice

- Developed 2010-2011 and launched earlier this year
- Advisory Committee – cross-sectoral (clinical and PDRS) and involving consumers and carers – chaired by A/Prof Alex Cockram
- Rationale: mental health services have a role in creating an environment that supports, and does not interfere with, people's recovery efforts



DoH Framework for recovery-oriented practice

- Purpose of Framework: to identify the principles, capabilities, practices and leadership that should underpin the work of the Victorian specialist mental health workforce
- Policy analysis, literature review, consultation



DoH Framework for recovery-oriented practice

- Provide broad guidance to individual practitioners and service leaders, spanning different practice settings and age ranges throughout the specialist mental health service system, specifically clinical and PDRS services



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Domains

- Promoting a culture of hope
- Promoting autonomy and self-determination
- Collaborative partnerships and meaningful engagement
- Focus on strengths
- Holistic and personalised care



Domains

- Family, carers, support people and significant others
- Community participation and citizenship
- Responsiveness to diversity
- Reflection and learning



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Sections within each domain

- Core principles
- Key capabilities – behaviours, attitudes, skills and knowledge
- Good practice examples
- Good leadership examples – activities and governance structures that could be expected of a recovery-oriented organisation



Process

- Good representation and involvement of consumers and carers
- Active input from committee members
- Working committee with good focus
- Generated plenty of best practice and leadership examples to guide the field



Where to from here?: Implementation issues



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Implementation

- Now for the hard work....
- Advice on implementation currently being considered by the Mental Health Workforce Expert Consultative Group
- Mental Health services are not so expert in the science and practice of implementation and (in clinical services at least), there is much mandatory training and change overload with inadequate consideration given to how best to achieve meaningful change



Some challenges



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Understanding of recovery

- Variable.....
 - Rehabilitation, social psychiatry and recovery have usually not been adequately covered in education, training or professional development of clinical mental health staff
 - Similar situation for current concepts and understanding of recovery
 - Difficulties with paradigm – increasing emphasis on elements of practice which are quantifiable / how to operationalise recovery?
 - ???can be taught or primarily need to learn by experience / supervision and mentoring



Outcomes for consumers (and families)

- Increasing emphasis on episodic treatment in clinical mental health services:
 - this does not necessarily fit with what consumers (and families) need and want (recovery may require sustained support and care to build on achievements, consistent therapeutic relationship, etc)
 - if consumer makes positive changes / improvements, these are often a trigger for discharge rather than creating a platform for re-negotiation of treatment goals to enable further improvements / recovery



Risk management

- Most clinical mental health services focus strongly on this
- Many organisations are devolving responsibilities to the 'front line staff' with increasing sense for these staff of being less supported by management in the event of an adverse event
- Linked with this, the impression permeates the system that the main role of managers is to receive data from the 'front line' so that they can monitor and report activity
- Clinicians cannot reconcile this emphasis with 'dignity of risk' or empowerment within recovery



Organisation and culture

- Procedural / technical skills prioritised
- Strong emphasis on particular evidence base derived from RCTs (rather than lived experience)
- Recovery is an inherently individual process – but organisational preference is to consider processes that can be readily categorised into fewer categories – for outcome measurement and planning
- Many clinical mental health services are arguably less enabling and more proscriptive and top down – consider parallel process implications for recovery?



Workforce issues

- Recruitment and retention continues to be problematic – many junior staff who do not stay long enough to understand and develop their contribution to consumer recovery
- Workload - emphasis on monitoring, medication, risk management, paperwork, outcome measures, KPIs
- Decreased job satisfaction and increased burnout - runs counter to necessary attitudinal change



Therapeutic relationship

- Therapeutic relationship / therapeutic engagement / treatment alliance as the essential vehicle for recovery has been de-emphasised
-use of clinician's personal qualities, including their essential humanity, also under-emphasised
- Expertise in skills of building a therapeutic relationship that supports recovery – fewer senior staff with relevant orientation and expertise?



Education and training of psychiatrists

- Majority of Victorian psychiatry registrars attend teaching sessions on diagnosis and psychopharmacology but very few attend sessions on recovery, social psychiatry etc
- Registrars tend to take the view that this is not their business / responsibility – they quickly take on the message that prescribing medication is their main role and that holistic care is simply not their business
- Linked with their training experience as first years – tends to be in inpatient psychiatry???



Opportunities



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Recognition of need for change in practice

- Increasing number of clinicians do recognise that there is scope for improvement
- Despite 'advances' in treatment, many consumers are not 'getting better'
- Whilst symptomatic improvement is not the same as recovery, recognition that there are limitations to medication means that there is capacity for other therapeutic approaches to be considered rather than a narrow adherence to medical model



PDRSS and clinical

- Closer working arrangements – sum of the whole is greater than the parts - rather than worst of both worlds?
- Collaboration could enable much-needed dialogue, reflection and mutual learning?
- Would address the (unintended?) schism between health and social care – consistent with recovery being a holistic process



Consumers and carers

- Opportunity for consumers and carers to take leading roles in education, training and service delivery
- Provides one of the best opportunities for attitudinal change which is essential for meaningful change in service delivery



Therapeutic relationship

- Reinstatement of the importance of skills in building a therapeutic relationship necessary to provide the right conditions for recovery
- Attitudes, values, experiences placed on equal footing with technical skills



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