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The Development of a Recovery-Oriented Mental Health System in Canada: What the Experience of Commonwealth Countries Tells Us

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Abstract

This article examines how the recovery concept has been introduced into national mental health policies in New Zealand, Australia and the England. Five overall themes are identified as critical in shifting to a recovery-oriented system: restructuring of mental health services; promoting mental health and preventing mental illness, developing and training the workforce; cultivating consumer participation and leadership and establishing outcome-oriented and measurable practices. These issues are vital in the uptake of recovery and should guide the overall direction of the Canadian Mental Health Commission's mental health strategy.

Recovery represents a radically new paradigm in mental health which has emerged over the past two decades transforming systems of care throughout the world. A recent seven-country comparison of health policy states that the recovery paradigm in mental health transcends international borders, and is the new guiding principle for the design and delivery of mental health services (Adams, Compagni, & Daniels, 2006). Canada is the most recent G8 country to propose a national mental health strategy, which builds on the premise that "recovery needs to occupy a central place in the transformation of the mental health system in Canada, as it has in many other countries " (Mental Health Commission of Canada, 2009). While research on mental health system transformation often focuses on reform in the US, the purpose of this article is to take stock of developments abroad over the past decade, through a review of mental health policy in three Commonwealth countries - New Zealand, Australia and England. We examine how these countries have attempted to integrate the recovery concept into their national mental health policies, and explore how these policies may inform the new Canadian mental health strategy.

The article begins with an overview of how recovery has emerged, and been defined by each country. We then describe the introduction of the recovery concept into their national mental health policies and major planning documents. We then present five themes common to mental health reform in the three countries, in which the recovery concept has been

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introduced. We conclude by comparing and contrasting these main themes with the major thrust of Canada's proposed mental health strategy.

Emergence of the Recovery Perspective in Mental Health

Recovery derives from a number of disparate bodies of knowledge in mental health. First, longitudinal studies conducted over the past fifty years challenged century-long beliefs about mental illness as an inevitably deteriorative condition. They establish that people with serious mental illness do show substantial clinical improvement over time, whether spontaneously or through treatment and specific psychosocial interventions, (Ciompi, 1980; D. Fisher & Chamberlin, 2004; Gagné, White, & Anthony, 2007; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b; Liberman, Kopelowicz, Ventura, & Gutkind, 2002; McGlashan, 1987, 1988; Pevalin & Goldberg, 2003; Rogers, Farkas, & Anthony, 2005). Second, advances in psychopharmacology offer persons with psychiatric disabilities new possibilities for stability and self-management of symptoms (Noordsy et al., 2000). A third catalyst to the emerging recovery perspective has come from work in the addictions and disability fields. The notion of being "in recovery" in the addiction self-help community suggests that, even when illness is long-term, a person can, and has the right to, reclaim his or her life in the community (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005: 482). Social models of disability include recovery-oriented approaches, such as Charles Rapp's widely disseminated "strengths model" (Ramon, Healy, & Renouf, 2007; Roberts & Wolfson, 2004). Fourth, William Anthony (1993; 1983) introduced a new recovery-oriented vision for psychiatric rehabilitation, hailing the 1990s as "the decade of recovery".

However, the writings and activism of psychiatric "survivors" provide the most critical channel for the development of a recovery paradigm (e.g., Chamberlin, 1978; P. E. Deegan, 1988, 1992; D. B. Fisher, 1994; O'Hagan, 1991). Recovery self help groups developed in North America as early as the 1930s. For example, one group of ex-psychiatric patients in the US organized WANA (We are not Alone) and went on to establish Fountain House. Recovery Inc., now an international organization which promotes the self-aspects of a cognitive-behavioral therapy developed by Dr. Abraham Low, followed in 1950 (Pratt, Gill, Barrett, & Roberts, 2007: 338). During the deinstitutionalization era, ex-patients of psychiatric hospitals tended to organize around their shared experiences of neglect and impoverishment, as little planning or funding was provided to support community living. Social movements of disaffected service users developed in several countries, initially in the US from the late 1980s and followed by New Zealand (Ramon et al., 2007), and drew upon the ideologies of anti-psychiatry and other protest movements (e.g., Brunton, 2004; Chamberlin, 1978; Everett, 2000; McLean, 2000).

Definitions of Recovery

Consumer narratives describe recovery as both a concept and a process. Patricia Deegan (1988) was the first to argue that recovery is more than a "cure" or "back to health" narrative. Recovery is associated with hope, engagement, social connectedness and self-determination (Ahern & Fisher, 2001; Frese & Davis, 1997; Ridgway, 2001). Considerable literature also focuses on recovery as the personal effort to reconstruct the identity that has

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been shattered by mental illness (e.g., Davidson & Strauss, 1992; Kelly & Gamble, 2005; Schiff, 2004). Empowerment, rooted in personal resourcefulness and resilience, is another core value in recovery (P. Deegan, 2005; Fisher, 1999).

Resnick et al (2005; 2004) completed two studies, from which they developed an empirical model of the recovery process based on four domains: empowerment, hope, knowledge and life satisfaction. In Canada, Provencher (2002) identified self-redefinition, spirituality, hope, empowerment and relationships as central elements in recovery. Ochocka, Nelson & Janzen (2005) defined recovery as a "process of personal change", observing that how people negotiate self and external circumstances is critical.

Overall, there is considerable tension between consumer definitions of recovery, and those of clinicians. Davidson and Roe (2007) present the conceptual dichotomy between them as "recovery in" versus "recovery from" mental illness. "Recovery in" mental illness, the consumer standpoint, conveys the concept of recovery as ongoing or without an endpoint (Davidson, Borg et al., 2005; Davidson & Staynor, 1997; Smith, 2000; Spaniol, Wewiorski, Gagne, & Anthony, 2002; Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003; Young & Ensing, 1999). Other studies describe "recovery in" as a process that focuses on the concept of self, or personal identity (Davidson & Strauss, 1992; Jacobson, 2001; Kelly & Gamble, 2005; Lunt, 2000; Oades et al., 2005; Piat et al., 2009; Schiff, 2004; Tooth et al., 2003). Yet recovery may also include a desire to return to the pre-illness self, or to reclaim what has been lost (Spaniol et al, cited in Pettie & Triolo, 1999; Young & Ensing, 1999). "Recovery from" mental illness, or clinical recovery, is defined by Davidson & Roe as the "amelioration of symptoms and the person's returning to a healthy state following the onset of illness" (2007: 463). Clinical recovery, as determined by outcome studies and expressed as approximation to cure, remains an important perspective in mental health. Liberman & Kopelowicz (2005) argue that operational definitions of recovery are needed in order to add symptomatic and functional measures of improvement to the more subjective attributes of recovery, such as hope, empowerment and personal autonomy (see also Silverstein & Bellack, 2008).

Yet there is evidence that consumer definitions of recovery may cut across the "recovery-in"/"recovery-from" dichotomy (Andresen, Oades, & Caputi, 2003). Some research suggests, for example, that clinical definitions of recovery may exist in the minds of consumers (Paquette & Navarro, 2005; Piat, Sabetti, & Bloom, 2009 forthcoming; Piat et al., 2009; Smith, 2000; Sullivan, 1994). Pilgrim (2008) distinguishes three positions adopted by mental health consumers in relation to the discourse around recovery: 1) acceptance of the biomedical, or "recovery from", perspective; 2) a "social recovery" perspective where consumers reject psychiatry altogether; and 3) a middle ground where consumers commit to "user involvement" in an effort to reform the system (2008: 299). Whatever position consumers adopt, most would agree with Lunt (2000) that *". . . the biochemical solution does not bring with it a dream, a goal, a journey, a direction, an inspiration, a faith, or a hope. These are what are sought in recovery."*

While the literature makes frequent reference to the importance of integrating the recovery concept into mental health policy as a way to support the transformation of mental health

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systems and services, studies on how nation states have actually done this are scarce. This article is one attempt to address this gap in the literature at a critical moment in the history of Canadian mental health reform.

Method

An online search was conducted to locate all mental health policy and planning documents published by the national health departments or ministries of the three countries. In addition, the list of references retrieved for Australia and England were validated by two mental health experts working in these countries. This process added fifteen references to our original findings. In all, the search generated a total of 231 documents. In order to select the most pertinent documents from the master list, the following criteria were used: 1) the national mental health plans, policies or strategies for each country, published between 1992 and 2009, were identified; 2) additional planning documents were identified, and selected based on a review of the national plans; and 3) documents had to include information on the integration of recovery into mental health services. A total of thirty-four policy and planning documents: 10 for New Zealand, 10 for Australia, and 14 for England, which serve as the basis for our analysis. The analysis entailed: 1) a review of mental health policies and planning documents for each country; 2) an examination of how the recovery concept was being introduced into system and service reform; and 3) the articulation of common issues and concerns, specifically in relation to the incorporation of the recovery concept into services.

Uptake of Recovery in the Three Commonwealth Countries

Mental health policies in New Zealand, Australia and England reflect different orientations to the concept of recovery. Only New Zealand identified recovery as the overarching value base for the entire mental health system: “a journey as much as a destination”, not only for individuals but for the mental health system itself (2007: 7). By contrast, Australia has focused on recovery as primarily an individual process and outcome, adopting Anthony’s well-known definition of recovery as “a personal process of changing one’s attitudes, values, feelings, goals, skills and/or roles . . . “ (Australian Health Ministers, 2003: 11). In England, the current 10-year *National Service Framework for Mental Health* (National Health Service, 1999) does not include any reference to recovery. Recovery was introduced subsequently through *The Journey to Recovery – The Government’s Vision for Mental Health Care* (Department of Health, 2001), and the *NIMHE Guiding Statement on Recovery* (2005), which provides several meanings of recovery as an individual process of positive change. British documents define a recovery-oriented system as an integrated network of culturally adapted services and supports that enhances people’s ability to reclaim and take control of life. The following section examines each country in terms of: 1) main features of their mental health systems; 2) overall content of mental health policies; and 3) how the recovery concept has been integrated.

New Zealand

New Zealand’s mental health system is one of the most restructured in the world, as described in *Te Haererenga mo te Whakaoranga: The Journey of Recovery for the New*

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Zealand Mental Health Sector (New Zealand Mental Health Commission, 2007), a report on the first decade of reform in that country. Main features of the system are: parallel authority between the Ministry of Health and the Mental Health Commission, decentralization of service delivery to District Health Boards, a mix of government, private and not-for-profit service provision, and a separate funding stream for mental health. The Mental Health Commission's original *Blueprint for Mental Health Services* (New Zealand Mental Health Commission, 1998)followed publication of the first National Plan, *Moving Forward* (New Zealand Ministry of Health, 1997), and has remained the foundational document for subsequent work in anti-discrimination, service development, and consumer leadership.

Workforce development and an aggressive anti-discrimination campaign have been central to New Zealand policy over the decade 1997–2007. Recovery guidelines for mental health providers were instituted in *Recovery Competencies for New Zealand Mental Health Workers* (New Zealand Mental Health Commission, 2001), and in *Let's Get Real: Real Skills for People Working in Mental Health and Addiction* (New Zealand Ministry of Health, 2008). The *Service Workforce Development Strategy for the New Zealand Mental Health Workforce 2005–2010* (New Zealand Mental Health Commission, 2005) opened the way to employment and leadership opportunities for persons with a history of mental illness. Anti-discrimination work, celebrated and further extended to 2013 in the report *Like Minds, Like Mine* (New Zealand Ministry of Health, 2007), has aimed at changing perceptions about mental illness within the mental health workforce, and in the media.

Recovery remains the overall thrust of the entire system according to *Te Tahuhu* (New Zealand Ministry of Health, 2005), the second national plan. *Te Tahuhu* proposes broad reform through: 1) expanded government interest in the mental health needs all New Zealanders from previous focus on those with serious mental illness; 2) greater emphasis on outcomes, both in terms of people ("what people should be able to do") and services; and 3) specific concern with trust and accountability in service delivery. The subsequent implementation plan, *Te Kokiri* (2006) reiterates the objectives in *Te Tahuhu* and spells out how they are to be tackled.

Consumer participation and leadership in the mental health system have also increased substantially since publication of the *Blueprint.* As the mission statement of New Zealand's Mental Health Advocacy Coalition asserts in *Destination: Recovery. Te Unga di Uta: Te oranga,* (2008) the purpose of mental health services is recovery; whereas self-determination is the foundation of service delivery.

Australia

Australia's national mental health strategy, established in 1992, is built on three foundational documents, including the *National Mental Health Policy* (1992c); the *National Mental Health Plan* (Australian Health Ministers, 1992b); and the *Mental Health Statement of Rights and Responsibilities* (1992a). This national strategy focused mainly on effecting structural changes in the service delivery system. Since Australia has a federal system of government, with funding, delivery and management of all mental health services a direct responsibility of the states and territories, the national strategy was based on a funding agreement between the Australian Commonwealth, and the states and territories (Adams et

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al., 2006; see also Department of Health and Ageing, 2007). In Australia, major policy contributions may also emanate from state-level governments, such as the recent *Pathways to Social Inclusion Proposition Papers* (VICSERV, 2008) which dealt with the issues of social inclusion, health inequalities, economic participation, and housing and support for the state of Victoria.

Australia's two subsequent national mental health plans, the *Second National Mental Health Plan* (Australian Health Ministers, 1998) and the *National Mental Health Plan 2003–2008* (Australian Health Ministers, 2003) prioritized the integration of mental health services within the general health system. Reformed service and practice standards for the mental health workforce were introduced in the *National Practice Standards for the Mental Health Workforce* (2002).

The recovery concept is incorporated for the first time in the *National Mental Health Plan 2003–2008* (Australian Health Ministers, 2003) within the theme of promotion and prevention. However, the recognition of recovery in Australian policy has its roots in a long-standing tradition emphasizing human rights, equitable access to services, and consumer and family participation. A document entitled *The Consumer and Carer Participation Policy* (National Consumer and Carer Forum, 2005) provides benchmarks for consumer roles in a recovery-oriented system.

The most recent *National Mental Health Policy 2008* (Department of Health and Ageing, 2009) adopts a "whole of government" approach to mental health as agreed by the Council of Australian Governments in the *National Action Plan on Mental Health 2006–2011*(Department of Health and Ageing, 2006). The *Action Plan* includes significant new emphasis on care coordination and governments working together, in conjunction with the earlier work which ranged from issues of promotion, prevention and early intervention to a concern for enhancing consumer and carer roles.

England

England's mental health system operates through a network of 80 Mental Health Trusts, established in the late 1990s under the National Health Service (NHS), to provide specialized and community-based services.(Adams: 37–39). While this "culture of change" reflects a move away from centralized control, it started to occur just as the recovery concept was first introduced. The main goals are similar to features of a recovery-oriented system: they include enhanced choice, shared decision-making and ultimately a "patient-led" national health service (Department of Health, 2003, 2005).

The current 10-year mental health policy, the *National Service Framework for Mental Health* (National Health Service, 1999), now in its last year, has been updated in a number of more recent and specific planning documents. The *Framework* contains a number of measures that are important precursors for a recovery-based system, including emphasis on system outputs, a sound evidence base for service models, as well as specific arrangements for service user and carer involvement. A coalition of national mental health organizations recently advanced a platform for possible future reform in a document entitled *A New Vision for Mental Health* (The Future Vision Coalition, 2008). The report proposes: 1)

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movement away from the medical concept of mental health to an integrated model; 2) emphasis on public mental health as a "whole population" issue; 3) focus in services on recovery as attaining a good quality of life; and 4) shift of power relations to give individuals, carers and families real self-determination.

British policy reflects particular concern for mental health promotion in the workplace (HM Government, 2005). The workforce is also viewed as the key to opening up life opportunities and social inclusion for marginal groups in society, including mental health consumers. The *Capabilities for Inclusive Practice* (National Social Inclusion Programme, 2007) discusses how to promote a "recovery culture" as the central element in more inclusive services. Another document, *From Segregation to Inclusion: Where are We Now?* (National Social Inclusion Programme, 2008), observed that peer support and consumer-run services have been lacking.

Since the recovery concept was introduced in England, the government has made a particularly strong commitment to the integration of recovery into mental health services through workforce training. A series of provider competency frameworks has been published over the past few years, including *The Ten Essential Shared Capabilities. A Framework for the Whole of the Mental Health Workforce* (National Institute for Mental Health in England, 2004); *New Ways of Working for Everyone. A Best Practice Implementation Guide* (National Institute for Mental Health in England, 2007b); *A Learning and Development Toolkit for the Whole of the Mental Health Workforce Across both Health and Social Care* (National Institute for Mental Health in England, 2007a); and *Support, Time and Recovery (STR) Workers. A Competence Framework* (National Institute for Mental Health in England, 2008). How to involve consumers in these training initiatives is described in the practice guide *Learning From Experience. Involving Service Users And Carers In Mental Health Education And Training* (Tew, Gell, & Foster, 2004).

Critical Issues in the Uptake of the Recovery Concept

While there is considerable overlap in the focus and specific concerns of national policies in mental health for New Zealand, Australia and England, five overall themes may be distinguished in relation to the uptake of recovery. These themes emerged as part of a process in which national policies from each of the three countries were compared and contrasted. The resulting five themes are common issues or strategic priorities included in each policy or planning document and relate to mental health recovery. The five themes are: 1) restructuring mental health services; 2) promoting mental health and preventing illness; 3) developing and training the workforce; 4) cultivating consumer participation and leadership; and 5) establishing outcome oriented and measurable practices. Within each theme, specific proposals for integration of the recovery concept emerge.

Restructuring mental health services

A recovery vision is beginning to emerge through two trends that characterize mental health service restructuring across all three countries:1) the integration of mental health services into standard health care; and 2) the development of greater inter-sectorial cooperation in service provision, including NGO and private providers. The general rationale is to

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normalize mental health services and to make them more accessible. This restructuring also includes promotion of a recovery culture in services, most particularly in New Zealand.

Service reform in New Zealand, under the current plan, *Te Tahuhu,* promotes both development of the primary health care sector, and better inter-sectorial collaboration. Measures include: building the assessment capabilities of GPs, providing better linkages between Primary Health Organizations (PHOs) and mental health providers, and strengthening PHOs in communities. The aim is to promote seamless transitions between services for service users, and continuity of care. The shift to a culture of recovery implies closer collaboration between service users and providers; use of tools such as a strengths model and advance directives; less use of seclusion; routine participation by users in planning their own recovery, as well as enhanced opportunities for leadership across services, and better social inclusion in their communities.

Australian mental health policy also prioritizes the development of links between mental health services and the wider health system. There are several benefits of making standard health services the point of entry for mental health service users in terms of promoting recovery: reduced stigma; enhanced potential for early detection and treatment; and greater equity in access to mental health services. The 2008 Australian national plan further states that services should be responsive to people's needs; they should promote positive outcomes and facilitate sustained recovery. Working within a recovery orientation in the Australian system implies the need to complement clinical care with community and support services focused on employment, stable housing, income support, education, and social and family support.

Even though recovery was only introduced in England after publication of the *National Service Framework for Mental Health* (National Health Service, 1999), standards two and three of the five national standards outlined in this document were aimed at coordinating primary care groups with specialist mental health services in order to better implement assessment and management protocols. The Future Vision Coalition, a national planning group recently formed to advise government on future mental health policy, looks toward an integrated policy model and a "whole life" framework of support for the future, with recovery fully adopted across the spectrum of care. "Experts by experience" can expect to take a strategic leadership role in policy development and service design as stated in the recommendations of this group (The Future Vision Coalition, 2008: 3).

Promoting mental health and preventing illness

All three countries have identified mental health promotion, and illness prevention as a central goal, with variable implications for the uptake of recovery. New Zealand provides the most coherent link between mental health promotion and recovery in observing that mental illness often results in social marginalization and stigmatization. Recovery-oriented services demand that the barrier of social exclusion, like discrimination, be eliminated. Illness prevention measures in the three countries address the risk factors for mental illness and suicide, and for protective factors that strengthen communities. Measures consonant with a recovery perspective include: incorporating strengths models; enhancing cultural awareness,

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and promoting access to the resources of mainstream society to encourage the full participation of mental health consumers.

While New Zealand acknowledges significant progress in anti-discrimination efforts over the past decade, the current plan, *Te Tahuhu,* proposes more proactive steps under the theme of mental health promotion. They are: to encourage employers to be more inclusive and supportive; to identify and eliminate discriminatory practices; and to enable consumers to gain support, protection and redress if they experience discrimination. In England, mental health promotion, including fighting discrimination and social exclusion, is first of the five standards in the 1999 *National Service Framework.* Aside from social inclusion, mental health promotion emphasizes equity for ethnic minorities in accessing services. England is now moving in the direction of a "whole population" approach to mental health, recognizing that mental health is an issue that affects everyone directly or indirectly.

Australia's mental health promotion theme is highlighted in the 2003 national strategy, which identifies a recovery orientation in services and a strong person focus as the goal of service provision. Key directions for integrating recovery include: increasing consumer capacity through self-help, self-care, training, building networks and advocacy; and support for consumer employment through other government sectors and businesses.

Developing and Training the Workforce

In all three countries workforce training has been a major priority. The main challenge has been how to train mental health providers, including GPs, in recovery values and practices. New Zealand recognizes, since the 1998 *Blueprint,* the need to put into place a mental health workforce that would promote recovery through its services. New Zealand consolidated its workforce training for the purpose of giving all occupational groups a strong psychosocial, rather than medical, emphasis in their training. The *Recovery Competencies for New Zealand Mental Health Workers* (New Zealand Mental Health Commission, 2001), is a foundational document which prescribes a set of ten major provider competencies, based on respect for consumer autonomy and recovery. These range from knowledge and understanding of recovery, support for peoples' resourcefulness, viewpoints, and rights, to cooperation and support for consumer participation in services.

Australia's *National Practice Standards for the Mental Health Workforce* (National Mental Health Education and Training Advisory Group, 2002)highlights workforce education and training as essential. Recovery is a goal, in the twelve practice standards, but is not linked to specific provider skills or attitudes. The 2008 national policy reiterates the need for an adequate mental health workforce, trained to provide high quality care that promotes early intervention and recovery, and is sensitive to cultural diversity and the rights of individuals. This policy also recognizes the increase in aboriginal and peer support workers, and commits to support their efforts.

As in Australia, England, in its *National Service Framework for Mental Health* (National Health Service, 1999), recommended: 1) workforce planning to meet future needs; 2) education and training, including a national program to address critical gaps in skills and cultural competencies; 3) recruitment and retention measures; and 4) a national leadership

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program. In 2001, the National Institute for Clinical Excellence initiated new service provider training and competency research in England. Only in the most recent practice guide: *Support, Time and Recovery (STR) Workers* (National Institute for Mental Health in England, 2008) has recovery been fully entrenched. Recovery-oriented practice includes a strengths model whereby service users are encouraged to abandon the "sick role", self-manage their mental health problems, and build natural supports.

Cultivating Consumer Participation and Leadership

One of the strongest themes to emerge in relation to the transition to recovery-oriented mental health systems is the involvement of consumers in planning and delivering mental health services. In *Te Haererenga mo te Whakaoranga* (New Zealand Mental Health Commission, 2007), New Zealand makes a strong case for consumer leadership, based on the assumption that reform of the mental health system must be recovery-based and consumer-driven. Policy includes major initiatives to certify non-clinical consumer workers trained in basic mental health and recovery-oriented practice, and to integrate them as part of the mental health, and mainstream, workforce. *Destination Recovery Te Unga ki Uta: Te Oranga* (New Zealand Mental Health Advocacy Coalition, 2008)advances ten strategic recommendations for district level leadership groups in the areas of governance, national-level systemic advocacy, transformational leadership, and models that support recovery-based practices.

In Australia, the issue of consumer participation was raised in the *National Mental Health Plan 2003–2008* (Australian Health Ministers, 2003), under the theme of "strengthening quality". The *Consumer and Carer Participation Policy* (National Consumer and Carer Forum, 2005) proposes a framework aimed at providing a best practice example of consumer participation. Its major thrust is that consumers have the right to participate as far as possible in developing policy, providing health care and representing their interests. If views of the Future Vision Coalition become policy, the next national plan for England promises to be both recovery-focused and consumer-led. The fourth element of their vision statement illustrates how far the knowledge and understanding of recovery has evolved in that country:

> Power relations need to shift in order to give real self-determination over the processes and direction of recovery to individuals, their carers and families. This will reflect a move from care as something which is done to service users by the system, towards a system of support built by the person and their advocates. (The Future Vision Coalition, 2008: 3)

Establishing Outcome-oriented and Measurable Practices

All three countries have expressed a commitment to outcome oriented and measurable mental health practices, including evaluations of recovery-based practices. This is in line with the aims of the research community that the recovery concept must be empirically grounded in terms that can be studied and measured in order for the field to advance (Silverstein & Bellack, 2008).

In New Zealand, recovery standards were part of an audit tool that providers were required to pass, by 2004, in order to receive continued funding. Current policy for 2006–2015,

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outlined in *Te Tahuhu* and *Te Kokiri,* re-emphases the concern for outcome as an overarching goal of the system. Outcome research includes: 1) portraits of service use; 2) consumer assessment tools; and 3) national data collection systems (New Zealand Mental Health Commission, 2007). This marks an important step in the transformation to recovery-based, and accountable, mental healthcare, as consumer and family assessments are part of the process. Recovery also runs through the eighteen quality assurance and performance indicators for New Zealand staff in *Let's Get Real: Real Skills for people working in mental health and addiction* (New Zealand Ministry of Health, 2008).

Australia has proposed a "new culture of measurement", whereby recovery-based performance measures must meet economic as well as clinical criteria. The *National Mental Health Plan 2003–2008* (Australian Health Ministers, 2003)called for clear and transparent accountability. As in New Zealand, the Australian quality control agenda is to be broadened from emphasis on inputs and structure, to measuring service impacts and outcomes. The establishment of consumer and clinician-rated measurement systems, and the monitoring and evaluation of service outcomes are key goals that have carried over into the 2008 national plan.

In England, the 2001 document introducing *The Journey to Recovery* (Department of Health, 2001) recognized the need for the NIMHE to undertake large scale studies to ensure that services were operating on the basis of best practices. A major piece of work was underway at that time to develop outcome measures relevant to the experience of service users. These included measures of quality of life, as well as user and carer satisfaction. The NHS has just invested Ł2 million in a five-year program to evaluate the recovery focus in mental health services. A randomized control trial of recovery-focused and traditional services is currently being conducted in South London and Gloucester (Thornicroft, 2009).

Implications of Experience Abroad for Canada's Proposed Mental Health Strategy

Policies in New Zealand, Australia and England provide us with a wealth of information regarding the uptake of the recovery concept into mental health systems. This information comes at a crucial time in the history of mental health reform in Canada, as a valuable point of reference on how to prioritize the transformation to our own recovery-oriented system. Our analysis gives an overview of the extensive work done in the three countries, highlighting five common themes that have directly or indirectly promoted recovery.

The five themes identified may be understood in terms of how they reflect the ongoing shift to a recovery orientation in mental health systems, and the centrality of the consumer in this process. Theme one identifies the overall thrust of mental health policy as the effort to structure services in a way that "normalizes", and better coordinates, service delivery for service users. Health promotion, the second common theme, tends to reinforce the benefits of moving mental health services into standard care by making links to anti-discrimination and social inclusion campaigns. Health promotion directly supports recovery by increasing consumer capacity in various ways. The third theme, workforce training, centers on the challenge of tooling all providers in recovery-based values and practices. This is ultimately a

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question of translating consumer knowledge – the knowledge of lived experience – to service providers, and of promoting more collaborative working relationships between them. Consumer leadership, the fourth theme, further underlines the principle that a truly recovery-based mental health system must be consumer driven. Consumer leadership is most highly developed in New Zealand through a variety of possible roles for consumers; yet England is also beginning to promote a mental health system "built by" service users and their advocates. Australia affirms the "right" of consumers to participate in service development. Finally, consumers provide a critical component in outcome evaluation, the fifth theme, and are viewed as the most important guarantors of system accountability.

Canada is at an early stage in the process of system transformation, but has taken the crucial first step of identifying recovery as the overarching principle guiding reform. While recognizing that health services are a provincial and territorial responsibility under the Canadian constitution, the Mental Health Commission of Canada, directed by the Hon. Michael Kirby, has assumed strong leadership in overseeing a number of designated projects. These include the elaboration of Canada's first national mental health strategy, *Toward Recovery & Well-being. A Framework for a Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2009), recently released for public consultation. Where does the Canadian mental health reform stand in relation to the issues and concerns emerging from policies, and the service reform experience, abroad?

In light of our review, we find at least three initial areas where the proposed Canadian strategy could be strengthened. Most crucial is the definition of recovery, advanced within Goal 1: "The hope of recovery is available to all". Recovery is defined as:

> . . . a journey of healing that builds on individual, family, cultural and community strengths, and enables people living with mental health problems and illnesses to lead meaningful lives in the community, despite any limitations imposed by their condition. Family caregivers, service providers, peers and others are partners in this journey of recovery (2009: 13).

This definition is, in our view, somewhat incomplete as there is no specific reference to the mental health system and this reflects a departure from the Kirby Commission's foundational insight that "recovery must be placed at the centre of mental health reform" (Kirby & Keon, 2006: 42). While inclusive communities and supportive others are undoubtedly essential to recovery, there needs to be a direct link to the organization and delivery of mental health services. The Canadian strategy would be greatly strengthened by adopting a definition closer to that of New Zealand, where the concept of recovery is firmly established as the single, overarching value for the entire mental health system, as well as the point of departure for reform at all levels of the system and for addressing negative perceptions of mental illness. In short, recovery needs to be a journey of healing for services as well as for individuals.

Second, two key stakeholder groups in the mental health system – service providers and mental health consumers – are conspicuously absent as the focus of any of the eight goals of the proposed mental health strategy. Mental health systems in Canada must embark on a massive effort to train service providers at all levels of the system, in order for recovery

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principles and practices to be fully integrated, and for change to occur. As well, mental health consumers must play a central role in any recovery-driven system. Consumers are the most legitimate and authentic spokespersons for recovery, as well as the natural overseers of a recovery-oriented mental health system. Their input needs to include formal evaluation of the services they receive. We suggest that Goal 8, calling for a social movement to advance the recovery paradigm, needs revision. What Canada needs is a "broadly-based *consumer* movement (that) keeps mental health issues out of the shadows – forever."

Third, as recognized in the important work of the Mental Health Commission of Canada, discrimination and stigma are the major barriers to recovery. Current initiatives to reduce discrimination need to focus primarily on discrimination in the media, in education and the workplace, but first and foremost within the mental health system itself. Change is needed in public perceptions of mental illness, as greatly affecting the prospects of mental health consumers to advance their own recovery, and reclaim a place in society. We suggest, based on our review, that the anti-discrimination goal, currently Goal 7, be given second priority as more reflective of its importance. As well, the notions of social inclusion, and recovery as a societal responsibility, need to be incorporated into mental health promotion campaigns.

Conclusion

This type of analysis has both strengths and limitations. It is one of the few known attempts to provide an overview of policies on recovery in Commonwealth countries, where health systems operate in political contexts similar to the Canadian system. The importance of policy cannot be overstated, as it sets the orientation for service delivery at all levels of the system. Our analysis focuses on primary documents, which provide guidelines for anyone interested in issues such as developing workforce competencies and standards, promoting consumer leadership or organizing anti-discrimination activities. It should be recognized, however, that policy does not guarantee results, and our analysis does not include implementation or evaluation studies on recovery and system reform. Our sources tell us little about outcomes, particularly at the regional and local levels. Research in these areas is urgently needed. As well, our analysis is limited to three countries. Future research should focus on mental health reform in other nations, for example the incorporation of recovery at the state level in the US since publication of the President's New Freedom Commission (2003).

Canadian policy makers and administrators can learn from the experiences of other Commonwealth countries engaged in mental health reform and the paradigm shift to recovery. As this review demonstrates, progress in the transition to recovery-oriented systems has been uneven, and has required at least a decade in order to put the necessary structures in place, train national workforces, develop consumer leadership, and change public perceptions about mental illness. It is encouraging to note that the priorities of the Kirby Report, and activities of the Mental Health Commission of Canada, closely mirror initiatives taken abroad to promote recovery. Experience elsewhere confirms the importance of continuing our efforts to position recovery at the forefront of change in the Canadian mental health system.

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