



Guest Editorial

Recovery in New Zealand: Lessons for Australia?

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Since 1998, all mental health services in New Zealand have been required by government policy to use a recovery approach. I was one of a small team of service users who wrote the recovery content in the Mental Health Commission's (1998) *Blueprint for Mental Health Services in New Zealand*. It was the first time 'recovery' had been mentioned in a central government agency document.

There is now wide acceptance of 'recovery' in New Zealand's mental health sector, but we have a long way to go to ensure that professionals understand recovery and that the mental health system is recovery oriented.

People in New Zealand had been talking about recovery for some years before *The Blueprint* and there was a lot of support for the concept. But we knew some service users didn't like the word. 'Recovery takes you back to where you were, but my experience transformed me.' 'I'll always have mental health problems so I'll never recover.' 'I don't believe I had an illness but recovery implies I did have one.' 'I don't see my madness as undesirable, so what is it I need to recover from?' 'To recover means to cover up again, but I don't want to cover up my distress.' We also knew that some professionals regarded 'recovery' as 'esoteric nonsense', as 'hard to grasp' and as lacking an 'evidence base'.

Some people, especially service users, had other concerns about recovery that went deeper than semantics or uninformed criticism: first, that

recovery is an import from America; second, that the Americans, in emphasising recovery as an individual process, have seemed to overlook that it is a social process as well; and third, that recovery in America evolved out of psychiatric rehabilitation and was perhaps driven more by professionals than by service users.

Despite these problems we went with the term 'recovery'. But we were determined to redefine recovery for the New Zealand context and to pass ownership of it to service users.

The Blueprint loosely defines recovery as 'living well in the presence or absence of one's mental illness'. It mentions the importance of hope and personal and social responsibility. It states that families, communities and people with mental health problems themselves need to be as actively involved in recovery as mental health services. The Blueprint also asserts that discrimination is the biggest barrier to recovery. Although the Blueprint reflects our early thinking about recovery, it shows some differences in emphasis to much of the mostly American recovery literature around at the time.

The American literature from the 1980s and 90s was strong on the individual process of recovery, especially the view that people with ongoing mental health problems have reason for hope and that recovery is the service user's own unique, self-determined journey. But it was the gaps in the American recovery literature that struck us most, from our perspectives as both New

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Zealanders and as service users. New Zealand is one of the few western countries that has seriously attempted to right the wrongs of white colonialism. The recovery literature was very monocultural and we needed to acknowledge cultural diversity and a connection to one's own culture as a key to recovery. Coming from the most individualistic country in the world, the American literature focused mainly on the individual's process rather than the social, economic and political processes that also enable recovery. Again, we wanted to emphasise citizenship and the breaking down of stigma and discrimination as central to recovery. An emphasis on social as well as personal responsibility for recovery may not sit easily with American libertarianism but it does fit New Zealand's traditions of egalitarianism and collective responsibility.

Much of the American recovery literature accepted, at least implicitly, the biomedical model of 'mental illness'. It did not place a great deal of emphasis on challenging the veracity or the dominance of the biomedical model in mental health services. We wanted the recovery approach in New Zealand to signal that there are many ways of understanding and responding to mental health problems and that no one way should dominate at the expense of others.

We also found that the recovery literature did not necessarily reflect all the values of the user/survivor movement. Yet we believed that user/survivor movement values should drive recovery more strongly than any other movement, such as psychiatric rehabilitation. Indeed, we have described recovery as the approach that service users have been asking for all along. So we put the spotlight on human rights, advocacy and on service user partnerships with professionals at all levels and phases of service planning, delivery and evaluation.

So, we added quite a lot of content to the recovery 'container' that we'd inherited from America. We were confident that New Zealanders would as a result come to associate the label 'recovery' with the fuller 'container'. Some service users in New Zealand still don't like the word 'recovery' but I have not heard one of them object to the way we have defined and interpreted it.

The Blueprint was light on detail, so the Mental Health Commission has continued to define recovery and to interpret what it might look like in the world of practice and experience. Our first major publication after the Blueprint was *Recovery Competencies for New Zealand Mental Health Workers* (Mental Health Commission, 2002a). These competencies fall into ten major categories that are elaborated in the text.

A competent mental health worker understands recovery principles and experiences, supports service users' personal resourcefulness, accommodates diverse views on mental health issues, has self-awareness and respectful communication skills, protects service users' rights, understands discrimination and how to reduce it, can work with diverse cultures, understands and supports the user/survivor movement, and understands and supports family perspectives.

The recovery competencies have been promoted to people who set the curricula in mental health education, but the document has also been used by services for quality improvement, job descriptions and performance appraisal. Later the Commission produced *Mental Health Recovery Competencies Teaching Resource Kit* (Mental Health Commission, 2002b), a starter kit of recovery articles and teaching aids for educators.

The Commission has also published a research report, *Kia Mauri Tau!* (Lapsley, Nikora & Black, 2002) which provides a thematic analysis of 20 Maori and 20 non-Maori people's narratives of recovery from disabling mental health problems. One of the interviewees led and wrote up the research. This research is unprecedented in New Zealand: it focuses on recovery rather than just illness or distress; it is a bicultural partnership between Maori and people of European descent; and it takes people with experience of mental health problems at their word. The research described people's journeys through mental illness and recovery. Mental illness shattered lives, and so recovery involved not just overcoming symptoms, but also developing personal resourcefulness and receiving support from others. Recovery processes were similar across cultures, but some contributors to recovery were identified that were uniquely Maori. After recovery, people had

changed profoundly, knowing and liking themselves better, empathising with others, and appreciating the important things in life.

Although recovery is widely accepted as a concept by people in the mental health sector in New Zealand, the Commission still has a long way to go to ensure that recovery as we have defined it becomes embedded in mental health services. So far, we've highlighted how individuals can contribute to recovery – both mental health workers and service users themselves. Now we are starting a project to define the features of service systems that support recovery.

Australia has not gone as far down the recovery track as New Zealand has, though Australians appear to be showing an increasing interest in recovery. If the New Zealand experience is anything to go by, there is still time for Australians to adapt recovery for their own circumstances, and most importantly, to ensure that a recovery approach in Australian mental health services is led by service users.

References

All these publications can be downloaded from www.mhc.govt.nz or a paper version can be ordered free of charge from info@mhc.govt.nz

Lapsley, H., Nikora, L., & Black, R. (2002). *Kia Mauri Tau! Narratives of Recovery from Disabling Mental Health Problems*. Mental Health Commission.

Mental Health Commission (1998). *Blueprint for Mental Health Services in New Zealand*.

Mental Health Commission (2002a). *Recovery Competencies for New Zealand Mental Health Workers*.

Mental Health Commission (2002b). *Mental Health Recovery Competencies Teaching Resource Kit*.