The Winston Churchill Memorial Trust of Australia

Report by Dr Bibiana Chan

2010 Churchill Fellow

The Churchill Fellowship to study peer-led recovery programs in North America: lessons learned for Australia’s culturally competent mental health services – Canada, USA

I understand that the Churchill Trust may publish this report, either in hard copy or on the Internet or both, and consent to such publication.

I indemnify the Churchill Trust any loss, costs or damages it may suffer arising out of any claim or proceedings made against the Trust in respect for arising out of the publication of any report submitted to the Trust and which the Trust places on a website for access over the Internet.

I also warrant that my Final Report is original and does not infringe the copyright of any person, or contain anything which is, or the incorporation of which into the Final Report is, actionable for defamation, a breach of any privacy law or obligation, breach of confidence, contempt of court, passing off or contravention of any other private right of any law.

Signed ........................................................Dated ................................
To my heavenly Father and my dear little angel Timothy
# Table of Contents

## Introduction .................................................................................................................. 4

Executive Summary ........................................................................................................... 5

Program ............................................................................................................................... 6

I. Background ....................................................................................................................... 7

1. What is recovery within the arena of mental health? ....................................................... 7

2. What are peer consultants or specialists? What roles do these peer consultants play in recovery-focused mental health services? ......................................................................................... 7

3. What is cultural competency in mental health services? ................................................. 8

4. What are the unmet needs in mental health services for Chinese migrants and other culturally and linguistically diverse communities? ......................................................... 10

II. The Development of Recovery Focused Services ......................................................... 13

1. Current development of consumer workforce in Australia ............................................ 13

2. The movement of recovery-focused mental health services in US: ............................ 13

3. Some examples of peer-led recovery services in North America .................................. 14

4. Chinese-Canadian Mental Health Services Providers .................................................. 20

III. Research challenges? ..................................................................................................... 24

1. Are randomised controlled trials the gold standard of medical and health research? .... 24

2. Could community-based participatory research in health be a viable alternative? ........... 25

3. Link between peer-led recovery-focused services ‘Citizenship and Community Enhancement Project’ (at PRCH in New Haven) and the Assertive Communication Program (in Sydney) .................................................................................................................. 26

IV. Recommendations: ........................................................................................................ 28

1. Recognise the contribution of peer consultants to mental health services and provide them with the necessary training, support and career development .............................................. 29

2. Explore the concept of citizenship in recovery-focused service development for culturally and linguistically diverse communities – what does it mean to once again become a productive member of society? ........................................................................................................... 29

3. Support consumer advocacy among CALD communities; advocacy is exhausting and need continuous support. ................................................................................................................................. 30

4. Foster international research collaboration and partnerships ....................................... 30

5. Develop inter-sectoral collaboration to expand community mental health programs ....... 31

6. Create innovative service models to cater for both men and women ............................. 31

Conclusions ....................................................................................................................... 32

References: ......................................................................................................................... 33
Introduction
I have been involved with mental health research since 2002. My interest and passion in this field is driven by my first-hand experience with clinical depression, and my quest for knowledge through research is an important journey of recovery. My professional training straddled the arenas of Science and Arts. I am privileged to have inherited a rich Chinese culture and have also spent a significant portion of my life in Australia.

Mental health service (or the lack of it) has attracted much attention since the turn of the millennium. The New South Wales (NSW) Community Mental Health Strategy 2007–2012 highlighted the importance of a recovery focused model in community mental health service. The 2008 Melbourne Charter called on national governments to ‘actively engage with those who are most adversely affected and socially excluded, such as people experiencing and affected by mental illness’. Thus, drawing on these two approaches, I became interested in peer-led recovery focused programs. Receiving the Churchill Fellowship has given me the opportunity to interact with other researchers and service providers in Canada and the USA. Most importantly, I observed peer workers in action and took home with me new ideas to expand the work to culturally and linguistically diverse communities.

I am grateful to the Winston Churchill Trust for the opportunity that the fellowship has given me. The privilege of travelling and representing the Winston Churchill Trust has enabled me to visit the top research centres in North America and reputable service providers. The six-week tour was exceptionally inspiring and encouraging; I’ve learned so many valuable lessons and expanded my professional network.

I would like to acknowledge my referees during the application process – Prof Mark Harris and A/Prof David Perkins. Without their generous words and support I would never have had this experience. I also dedicate special thanks to A/Prof Jean-François Pelletier for introducing me to his colleagues at Yale, McGill and the Mental Health Commission of Canada, and Mr Terrance De Lisle (LCSW) for connecting me with the Wellness and Recovery Service at Brooklyn’s Kings County Hospital Center. There are many people I owe gratitude to, especially those who supported me during an awful spell of clinical depression two months before I was due to travel. Last but not least, I would like to thank the selection panel for their commitment and hard work.

Finally I would like to dedicate this report to the remarkable people I met during my travels. There are too many of them to be named one by one. Everyone I met was inspiring, passionate, and so generous with their time in answering my questions. It was incredible to see the peer workers fostering cultural change at their workplace. I was also amazed by the quality and quantity of mental health services for Chinese migrants in Canada. The research collaborations that I have been able to establish were the highlights of my Winston Churchill Fellowship.

---

1 Recovery is a process and an outcome. Anyone suffering from some form of mental ill-health can take on the journey of recovery.
2 The Melbourne Charter is the outcome of a worldwide discussion that was initiated by the organisers and participants of the Global Consortium for the Advancement of Promotion and Prevention in Mental Health (GCAPP) conference in Melbourne, Australia, September 2008.
3 ‘Peers’ are individuals with lived experience of mental illness who can be at any point of their recovery.
Executive Summary
Dr Bibiana Chan, 19 French’s Road, Willoughby NSW 2068. Ph: +614 1261 3073
Research Fellow, UNSW Research Centre for Primary Health Care and Equity
Churchill Fellowship to study peer-led recovery programs – lessons for Australia’s cultural competent mental health service – Canada and USA

Highlights:
- One week in Ottawa to visit the University of Ottawa and the Mental Health Commission of Canada and to conduct an Assertive Communication Workshop at Yet-keen Chinese Senior Day Centre
- Three days at McGill University, Montreal to learn about cultural consultation
- Two days at Brooklyn’s Kings County Hospital Center to observe peer workers in action
- Three days at Yale Program for Recovery and Community Health to discuss research collaborations
- Three days in Washington DC to attend the World Sixth Conference in Mental Health Promotion and Prevention of Mental and Behavioral Disorders
- One week in Vancouver to visit various recovery focused programs (mainstream and Chinese-specific)

Recommendations:
I am very inspired by all the peer workers I met, who have proved how they add value to mental health services. My recommendations are based on enhancing current practices in Australia, through service models adopted overseas. I also hope to establish international research collaborations to provide more evidence-based guidelines to advance recovery focused mental health services for culturally and linguistically diverse communities.

1. Recognise the contribution of peer consultants to mental health services and provide them with the necessary training, support and career development.
2. Explore the application of citizenship theory in recovery focused services – the positive outcomes associated with reinstating one’s full citizenship as a productive member of society.
3. Support consumer advocacy among culturally and linguistically diverse (CALD) communities – advocacy can be exhausting and need much support, both practical and emotional.
4. Foster international research collaborations and partnership to further establish research evidence to inform practice.
5. Develop inter-sectoral collaboration to expand community mental health programs – to foster inter-sectoral collaborations between various services making it easier for migrants to navigate.
6. Create innovative service models to cater for both men and women – an innovative approach to create programs for participants of both genders to develop empathy for each other.

Implementation and dissemination:
- Discuss experiences with colleagues, the NSW Consumer Advisory Group and other parties interested in peer-led recovery programs.
- Circulate the URL (when available) of this report to relevant colleagues, both local and international, within my network.
- Organise interviews with SBS Radio and Chinese Radio to share my experiences.
- Collaborate with Yale Program for Recovery and Community Health to apply for an Australian Research Council Linkage Project Grant.
- Submit a manuscript to the Australia and New Zealand Journal of Psychiatry to share the lessons learned.
Program

25th – 30th October 2010
Ottawa
Royal Ottawa Mental Health Centre
University of Ottawa – C.T. Lamont Primary Health Care Research Centre
Mental Health Commission of Canada
Somerset West Community Centre (Yet-keen Chinese Senior Day Centre)

1st - 5th November 2010
Montreal
CSSS CAVENDISH Centre for Health & Social Services
McGill University – Participatory Research At McGill (PRAM)
McGill University – Cultural and Mental Health Research Unit

5th -10th November 2010
New York
Kings County Hospital Center, Department of Behavioral Health

11th – 16th November 2010
New Haven
Yale University, Recovery and Community Health Program

17th - 23rd November 2010
Washington D.C.
Mental Health Promotion Conference

24th – 30th November, 2010
Vancouver
Vancouver Coastal Health
Canadian Mental Health Association
Chinese Mental Wellness Association
Canadian Mental Health Association
I. Background

1. What is recovery within the arena of mental health?

Recovery is a complex multifaceted concept; it is a process and also an outcome. It promotes hope, self-agency but also interdependence; systematic effort is needed for it to occur. The Connecticut Department of Mental Health and Addiction Services has adopted the following definition:

*Recovery involves a process of restoring or developing a meaningful sense of belonging and positive sense of identity apart from one’s condition while rebuilding a life despite or within the limitations imposed by that condition.*

Borrowing from the concept of recovery in other chronic diseases (e.g. asthma or having a recent heart attack), individuals who recover from an episode of clinical depression or psychosis can continue to view themselves as vulnerable to future episodes. They may be considered to be ‘in recovery’ (Yale Program for Recovery and Community Health 2008).

2. What are peer consultants or specialists? What roles do these peer consultants play in recovery-focused mental health services?

Peer workers⁴ (consultants/counsellors/specialists) are individuals with lived experience with mental illness. They usually act as role models for recovery, providing mentoring and coaching, connecting people to community supports and most needed services, and facilitating the establishment of new social networks that support these recovery services. By doing so, they introduce a new concept of recovery to their communities, a concept that carries a powerful message of hope and self-agency. This in turn helps the peer consultants to promote their own recovery even further. Adopting a non-medical model, these paid peers link their clients with social services that expand the continuum of care from clinical settings to the broader communities. Their services include engaging clients into professional treatment or therapy and at the same time connecting them to support services, as well as providing a post-treatment safety net to sustain clients’ treatment gains. It makes a lot of sense for peers from a similar cultural background to support each other. The next section briefly discusses the development of cultural competency training among health professionals in Australia and Canada.

⁴ Different terminologies including peer workers, peer consultants, peer counsellors and peer specialists are used by different organisations or different countries.
3. What is cultural competency in mental health services?

‘Cultural Competency in Health Services’ may mean different things depending on individual perspectives (health service providers or patients) and cultural/ethnic backgrounds. In a nutshell, **culturally and linguistically appropriate health care**…

a. meets community needs, promoting **optimal health service** provision and patient safety;

b. encourages increased usage of interpreter services to improve health outcomes and improve patient satisfaction;

c. identifies the need for **staff training** to improve the experience of culturally and linguistically diverse (CALD) consumers and their health outcomes;

d. ensures that culturally appropriate health services are **cost effective**.

(Spencer 2005)

Traditionally, discussion of ‘cultural competency’ often embeds a notion that services and resources for the ‘other’ or minority communities are ‘add-ons’ which revolve around the
mainstream dominant culture. Paradoxically, the distinction between ‘dominant’ (us) and ‘non-dominant’ (them) itself is a cultural construction. Cultural competency training courses usually describe in detail the characteristics, behaviours, cultural beliefs, values and practices of an ethnic group and how services should be adapted to better meet their needs and sometimes to counter (implicitly inferior) cultural beliefs. Stereotyped behaviours are reinforced and commonalities are usually not mentioned. This notion is reinforced by the conscious effort to accommodate individuals or groups who are ‘marginalised’. This imposed sense of their ‘otherness’ may inadvertently tell them that they are the minority or even second class.

Although it is impossible to train every health professional to be competent and confident to treat clients from every ethnic group in a country (over 100 different ethnic groups are in Australia, speaking over 200 different languages), some form of a ‘cultural consultation service’ (CCS) seems logical. Most states in Australia offer bilingual psychological services or interpreter assisted assessments and therapies, but a multidisciplinary approach is not readily available. I visited such a service offered by the Cultural and Mental Health Research Unit, Division of Social and Transcultural Psychiatry at McGill University in Montreal, Canada. (http://www.mcgill.ca/tcpsych/publications/report).

The objectives of this service are to provide a specialised service in mental health and to improve the accessibility and cultural appropriateness of mental health services for the multicultural population of Montreal (including immigrants, refugees, ethno-cultural groups, and Aboriginal peoples. This program is to serve as a model for similar services in other cities of Canada. This project also serves other specific objectives, such as identifying gaps in existing services to people from diverse cultural backgrounds and offering ongoing professional training as well as promoting the development of competency in intercultural intervention among mental health practitioners, particularly those who offer front line or primary care services.

I sat in their final team meeting where the case manager from a referral agent and the CCS team (psychiatrists and psychologists) were all present to discuss the outcomes of the cultural consultation. Due to confidentiality of the case, I do not describe any details here but share my reflections. I was impressed by the dedication and professional expertise the CCS team provided to the referral agent and how they helped the case manager resolve a very complex case step by step with clear and practical recommendations. The psychologist in charge of the consultation pointed out the bias and traps into which service providers (without insider knowledge of the cultural background of the case) could easily fall. Regardless of how well our professional training enables us to stay objective, it is a cultural lens that allows a service provider to gaze into the root of a multi-layered and complex case. The most valuable lesson for me was that the multidisciplinary team could leave behind their pride and genuinely work together to peel off each layer of the problem to get to the bottom of it. This could only happen thanks to the expert guidance of the CCS team.

In my own research (Chan 2007), undertaken in Sydney, both Chinese and Australian informants agreed that trust was the ticket to accessing sensitive information. One aspect of cultural competence is what health professionals call ‘social competence ’ in history taking,
skill that is fundamental to establishing rapport during any diagnostic interview. Without the development of rapport patients may feel misunderstood or disrespected, which undermines an optimal therapeutic relationship. But being able to engage with clients quickly is a generic skill any clinician can acquire, regardless of their cultural or linguistic background. From my observation of the peer counsellors/specialists/support workers in action throughout the tour, I could see their strength in client engagement and in showing respect to their clients. Further details are described later.

4. What are the unmet needs in mental health services for Chinese migrants and other culturally and linguistically diverse communities?

a. Sydney, Australia

Under-utilisation of mental health services by Chinese-Australians is an issue beyond access. In the focus group narratives of a study to explore help-seeking behaviours among Chinese in Sydney, there was no mention of common structural hurdles to services like ‘inconvenient opening hours of clinics’ or ‘long waiting time to see specialists’ (Chan 2007). This does not imply that these hurdles were not present, but reflects a more serious problem:

*Is there actually something to access?*

*Are existing services culturally sensitive or appropriate for the Chinese communities?*

If illness experiences are shaped by culture, so too are concepts of illness. Chinese people still holding traditional or indigenous views commonly believe in the concepts of ‘hot/cold imbalance’, ‘emotional imbalance’ and ‘psychological imbalance’ (Chan 2007). These concepts can be traced back to the cultural belief in external *yin/yang* forces in the cosmos and the internal *yin/yang* balance of *qi* in the body. But not every Chinese patient objects to Western psychiatry. In my own experience I have always adhered to my medication regime. If a Western-trained health professional believes that consultation with a psychiatrist would be appropriate for a particular Chinese patient, prior communication with bilingual GPs or psychologists may help to understand the patient’s own explanatory model and ensure that such a referral is appropriate. The point of caution is whether the treating health professionals make an effort to listen to how individual patients make sense of their emotional distress, whether they are given the different options available. Sometimes more than one form of help is required to deal with the complex mechanisms governing human emotions.

A culturally competent practitioner will adopt a pluralistic, non-discriminatory and integrated approach that acknowledges that a person may be facing difficult circumstances that cannot be fixed by medicalising either the somatic or psychological symptoms. Peer consultants would fit well in such an approach, as ‘individuals in recovery’ who have ‘been there and done that’ and can share their recovery stories with those yet to find their path to recovery.
b. **Ontario, Canada**

*Interview with Dr F. Mawani, Senior Policy Analyst at Mental Health Commission of Canada (MHCC) to share ideas on improving the uptake of mental health services to CALD communities.*

Besides cultural competency, new concepts like ‘cultural safety’ have emerged recently in Scotland, New Zealand, Australia and Canada. The Mental Health Commission of Canada (MHCC) believes that *recovery* including hope, empowerment, choice, and responsibility should be the focus of the mental health system in Canada. Dr Mawani gave an example to illustrate how service gaps could be identified. During the 2006 Boxing Day tsunami there were already a couple of bilingual psychiatrists available to provide care and support to people from the Sri Lankan community in Toronto, who experienced trauma as a result of grief for relatives lost in the event. Yet few people accessed their services. Only when someone from this community took the initiative to approach a group of mental health professionals specialising in trauma, reporting their concern about an increase in suicide rates within their community, was the mental health service able to have a huge impact on the Sri Lankan community. Through that open invitation from the community wanting to be connected to the service providers, the door to a much needed service was also unlocked. The research team within the Centre for Addition and Mental Health Cultural and Community Health Studies Department was flooded with requests for support. The research group took on a leadership role in the project and set up initial meetings to invite all kind of stakeholders, including the school board, to be involved. An advisory committee was formed, interviews were conducted, affected youth and children were assessed and referred appropriately. This was an excellent example of how inter-sectoral collaboration was triggered by a natural disaster. The service infrastructure should always be there to respond to an upsurge in demand for mental health services.

*Interviews with Dr Z. Merali (CEO) and Dr M Decotes, Institution of Mental Health Research (IMHR), Ottawa, to learn about the demand on mental health services among people from diverse ethnic backgrounds in the state of Ontario.*

Dr Merali described Canada as one of the most cosmopolitan countries in the world, with many people from diverse ethnic backgrounds. He saw the need to address stigma attached to mental illness especially for people from different ethnic backgrounds. As with the situation in Australia, the first port of call for mental health services is usually the family physician. According to Dr Merali, there were not enough family doctors to cater for the health needs of immigrants, and thus language and cultural interpretations became very important in bridging the services.

There has been some initiative to provide psychological services to the Asian communities. Within the primary care settings, there have been small group educational talks to address cultural issues of clients from diverse backgrounds. The Ontario Psychologists Association has a registry of members who speak a language other than English. Dr Merali pointed out that one of the strategies to reduce stigma was to integrate mental health services within primary health care. The World Health Organization has long been advocating such integration for the benefits of reducing stigma, improving access to care, reducing chronicity, improving social integration, and protecting human rights (WHO 2007).
In Ottawa there is an Aboriginal in-patient unit, the Odawa Native Friendship Centre, which caters for hospitalised youth and provides services to resolve family conflicts or issues and organise community placements. In terms of utilisation of culturally appropriate services, there is a service called ‘Immigrant women against violence’ (a similar service is also available in Australia). But many women are hesitant to phone or talk to these service providers about domestic violence. The level of integration of mental health service into primary care varies among the jurisdictions of each province in Canada. The general belief among the health professionals, however, is that mental health patients are not treated with the same urgency and respect as those with physical illness. The Institute for Mental Health Research (IMHR) is a tertiary specialist service with psychiatric beds that treats more severe cases and patients with co-morbidities. Dr Merali emphasised again that the first port of call was the family doctor, then primary care hospitals, and then tertiary hospitals.

Another challenge in Ottawa’s primary health care is the long waiting list to register with a family physician, because of the shortage of doctors. Patients might have to use a ‘walk-in’ clinic where they would be seen by different family physicians, thus lacking the continuity required to provide quality care. There has been a lack of acknowledgement of the need to also adopt a ‘chronic care approach’ to mental health patients. Senator Michael Kirby of Canada once said ‘Mental health is the orphan of the health care system’. Only 7% of the health care budget was allocated for mental health care in Canada. It was not surprising to see a very small percentage of funding directed to the ethnic communities.

MHCC recently published a document Toward Recovery and Well-being (MHCC 2009) to provide a framework for developing a more detailed mental health strategy to facilitate the recovery of people living with mental health issues and illnesses, and foster the mental health and well-being of everyone living in Canada. Dr Decotes provided some examples of other mental health services, such as the newly opened Women’s Resource Centre located in the same building as the IMHR, specialising in women’s mental health within a recovery framework. The National Anxiety Screening Day was able to raise mental health awareness among men, with 50% of the respondents being male. Unfortunately, not all male respondents followed through the screening to take up the recommended services. Dr Decotes suggested that some changes in terminology could be helpful. For example, using the term ‘stress injuries’ to address the post-traumatic stress disorder of servicemen after return from overseas placement and combat exposure might help potential service users see the parallel of their mental health concerns with those of a physical or biological nature. Sometimes, parents or mothers who accessed health services for their children were seeking help for pressing family issues which were likely to affect their mental well-being. Dr Decotes could see a need for early intervention, especially in the field of youth services, to collect genetic information about any predisposition to mental illness ahead of time.

The interview with Dr Merali and Dr Decotes gave me a glimpse of the gaps and unmet needs in general and in other ethnic communities in accessing mental health services in Ontario. There are several parallels to the gaps in service provision to culturally and linguistically diverse communities in Australia.
II. The Development of Recovery Focused Services

1. Current development of consumer workforce in Australia

The consumer movement in Australia started as early as the 1960s. In the 1980s, many consumer advocacy groups sprang up following the deinstitutionalisation of people living with mental illness, pushing for more consumer involvement in planning, implementation and evaluation of mental health services. This movement led to consumers being employed as part of the paid service team in various mental health services. In the early stages peer workers have various roles and tasks, including peer support, mentoring of fellow consumers, advocacy, and education and training of service providers, to name a few (McDonald 2010).

Peer workers experience inconsistencies in titles, roles, responsibilities, training and education, and remuneration. Without clear guidelines, these peer workers face many challenges in their employment. According to the NSW Consumer Advisory Group (McDonald 2010), the challenges include role conflict and confusion, dual relationships (as providers and former clients), boundary issues, tokenistic or inadequate remuneration, discrimination by other staff (non-consumer), limited access to professional development, and negotiating reasonable workplace accommodation.

Despite these challenges, the contribution of the consumer workers has been acknowledged by the mental health services locally and abroad. Their lived experiences and personal knowledge as consumers are valuable to other service users. To these peer workers, job satisfaction and active employment are the greatest benefits they enjoy. They are once again productive member of society. In 1993, six consumer workers and a coordinator were employed at Rozelle Hospital, NSW. This was the first consumer workforce in Australia. There are now approximately 58 consumer workers employed in NSW (McDonald 2010).

2. The movement of recovery-focused mental health services in US:

I first learned about recovery-focused mental health services during Prof Steve Onken’s visit to Sydney in 2007. He defined recovery as ‘the ongoing, interactional process/personal journey and outcome of restoring a positive sense of self and meaningful sense of belonging while actively self-managing psychiatric disorder and rebuilding a life within the community (Onken et al 2004). Fundamentally, when a person’s life has been complicated by the various challenges accompanying a psychiatric diagnosis, that person is also affected by the way society responds to this label.

People who suffer from some form of mental ill-health are still as capable as anyone else of living a full life and working with others in their communities to accomplish their goals. Within Onken’s framework, when an individual recognises that recovery is possible, a first order change within the consumer has taken place. A second order change brings about a change within the system itself: i.e. when the mental health service system incorporates and honours individual recovery as a routine component of care and treatment. Finally, change in one part will have an impact on other parts of the system and potentially on the system itself;
this adds the *interactional dimension* to the recovery framework. There is no better way to describe this interaction than this quote from a consumer advocate:

*Recovery is not so much getting mainstreamed, but expanding the mainstream to incorporate the fringes* (Deegan 1996).

This recovery framework is a strength-based concept; a consumer in recovery has the ability to participate fully in the community by building on strengths and reintegrating into the social network and the community. These networks become important resources for consumers in the recovery process. It is crucial that people in recovery feel accepted and welcomed by the community. Service providers need to ask themselves:

*Do treatments cure disorders, or do relationships heal people?*

A noticeable shift in initial history-taking is the change from asking ‘What’s wrong with you?’ to ‘*What happened to you?*’, presuming that most consumers have been exposed to abuse and other traumatic experiences. With such a simple change in the way service providers interact with their clients, they engage clients to move forward towards well-being rather than focusing on symptom reduction. This encourages consumers to identify and tap into their own capacities. To share their stories about ‘what has happened to you’, they need to feel safe. Peer consultants have been recognised as able to engage with their clients quickly and to establish rapport and trust (Jewel et al 2006).

Moreover, consumers need to be supported to utilise their personal and collective power to fulfil their aspirations. Such power can include power through establishing relationships with carers and service providers, power through choosing from the available options, power through inter-dependence, power through vital engagement, and power through peer-to-peer connections. Such an approach is particularly relevant to collective-oriented cultures, where the self is defined by the multiple relationships one has with significant others.

### 3. Some examples of peer-led recovery services in North America

#### a. Wellness and Recovery Service, Department of Behavioral Health, Kings County Hospital Center (KCHC), Brooklyn, New York

I visited the Wellness and Recovery Service, Department of Behavioral Health, KCHC. The Service was formalised in 2009, but peer counsellors had been employed prior to 2009. The concepts of wellness and recovery are integrated into all aspects of behavioural health care at KCHC. Peer counsellors must complete a 6-month Howie the Harp Accredited Course for peer support workers and undertake a 3-month internship on clinical placement to be eligible to work as peer counsellors at KCHC. There are currently 27 peer counsellors (from entry level 1 to supervisory level 3) employed by the Wellness and Recovery Service. They form one of the largest peer workforces in the U.S. As part of their induction program they are given peer counsellor in-service training and orientation (delivered in four parts over 4 weeks). Selecting the right candidate for the job is of utmost importance. During the recruitment process, potential applicants are asked the following questions:

1. *Why do you want to work at Kings County?*
2. **What assets/attributes do you bring along?**
   (Empathy, personal experiences, 12-step model, desire to give back...)

3. **What is it that you have to leave at the doors to be successful?**
   (Over-identify with the patient, burn-out, balance/boundary issues/self-care)

At KCHC, the peer counsellors’ duties cover the following:

- Having experienced and navigated the health system, giving a voice and advocating for service improvement
- Facilitating the liaison process between staff and clients
- Providing a role model through their personal journey
- Helping clients to stay well
- Use cognitive behavioural therapy (CBT) principles and peer support
- Being an active listener and using self-disclosure when necessary
- Preparing for client discharge and assisting clients to integrate back into their community
- Encouraging clients to become productive members of society

During my visit, I sat in on their regular staff meeting and took part in their discussion of ‘methods of engagement with clients’ that worked for them. The following are some examples:

- To explore cultural/spiritual practices with clients and acknowledge their role in recovery
- To listen with empathy. When a peer counsellor gave a young teenager her full attention, the young girl was very impressed and said ‘No one talks to me when I am in this state!’ (of paranoia)
- To help clients help themselves, tapping on clients’ strength.
- To help clients see the light at the end of the tunnel; the peer counsellor’s own recovery journey can be a convincing example.
- To admit to their identity (as a peer) and explain how they can help.

The Wellness and Recovery Service conducted a survey in April 2010 to evaluate how other interdisciplinary team members (non-peer) viewed the impact of peer counsellors in the adult inpatient services at the Department of Behavioral Health. A total of 119 surveys were collected, some of the key findings were:

1. Over 95% of respondents either strongly agreed or agreed with the following three statements
   - *Overall, peer counsellors have shown that they are an invaluable addition to the interdisciplinary, patient-centered care provided at Kings County Hospital Center*
   - *Peer counsellors contribute to a change in the culture of the unit to a more recovery oriented – that each individual being service at KCHC can set goals, improve their well-being and identify meaningful activities and societal roles of their choosing.*
   - *Peer counsellors de-escalate potential agitated behaviour.*

2. 99% of the respondents either strongly agreed or agreed with the statement
   - *Peer counsellors have an obvious presence on the unit.*
At Brooklyn’s Kings County Hospital Center a variety of recovery-focused programs are offered to their outpatients, and are well received by both male and female clients. I participated in their weekly ‘Media Room’ and was interviewed by one of the clients (the TV news reporter for the day). Much preparation was done before the ‘broadcast’ with the help of staff; there was a working team (fellow clients) to research for the news and write the script. They tried to involve as many fellow clients as possible. That was an activity on its own. News covered included celebrity gossips, headlines and sports. This ‘Media Room’ helped participants to restore their concentration and listening skills and most importantly confidence and self-esteem.

The peer counsellors’ passion for their work is indeed inspiring. For their clients, they give HOPE! They help clients to see that there is light at the end of the tunnel. They should congratulate themselves for the high level of recognition by other members of the interdisciplinary team. Not only have they been able to instil first order change within their clients but also they have created second order change in the system by winning their colleagues over. I was impressed by the leadership and commitment of the Director of the Wellness and Recovery Service, Dr Azaunce, and the Assistant Director, Mr Edwards. Without their enthusiasm and support, the impact of peer counsellors might not have reached this high level.

b. Drop-in Counter at Connecticut Mental Health Center, New Haven

As part of my visit to the Yale Program for Recovery and Community Health (PRCH http://www.yale.edu/PRCH/), I was introduced to two peer specialists at the Drop-in Counter at the Connecticut Mental Health Center.

At the counter, an information table was set up offering various fact-sheets on different psychiatric diagnoses and other brochures on general health and wellness. There were flyers about the community news and activities if anyone was interested. One peer specialist explained to me that they generally sat behind the counter and made clients feel welcomed. They would listen to clients but try not to talk too much, other than providing some reflective statements as support. Sometimes they brought clients a glass of water and showed them how to get to certain places if they were unsure. The range of services covered providing hospitality, providing information (including fact-sheets on different diagnoses), connecting clients with community resources, and giving out fact-sheets on different drugs to family members. Most importantly, peer specialists listened to their clients and provided feedback and support.

Different types of peer position were available in Connecticut apart from the drop-in counter, some private residential services employed peers to facilitate different activities. When a peer specialist who had worked at the Drop-in Counter for over 12 months was asked what was most rewarding, the answer was:

Seeing clients get better, it’s a great feeling!

Details about peer specialists mentioned in this report (other than their approximate length of service) are omitted to protect confidentiality.
A peer specialist who had been on the job for only 2 months said:

They opened it up and talk to me, that’s very rewarding for me.

During their training, peer specialists learned a series of different tasks, including basic active listening skills, how to talk to clients, what to say and what not to say. Setting boundaries was important too, as some clients might want to establish contact outside the work setting. Prior to commencing their position, peer specialists received training for a month, 4 hours per week. They also had supplemental training, a cardiac-pulmonary resuscitation class, and on-the-job training, with supervision from fully qualified mental health professionals. Some supervisors recommended courses for peers to further develop their skills.

Although clients could be difficult at times, peer specialists were trained to take nothing personally. One specialist said,

When things escalated, I just stepped away and let that client calm them. The positive encounters were much more than the negative ones. It’s been a great job overall.

When asked about remuneration, one peer specialist said the pay was somewhat decent, but it would be better if there were more full-time jobs. Most peer specialists worked part-time, depending where they were based. The hours varied from 5-10 to 10-20 per week, but several part-time positions might be fitted into a full-time job.

Maintaining one’s own well-being and avoiding burn-out are central to the peer specialists. Support from the team and regular staff meetings to share any ongoing issues or challenges are some of the measures used to ensure that everyone on the team was being looked after. The peer specialist described the team as a family who all worked together to support each other. Having regular supervision with one’s supervisor also helped. Supervisors assisted the peer specialists to address any problems and were generally very forgiving of mistakes.

Continuing professional development will benefit both the peer specialists and the standard of the services.

c. Citizenship Community Enhancement Project (CCEP), New Haven

I visited the Yale PRCH at the same time as a group of French-speaking researchers and mental health professionals from Canada and France were present. Prof Davison, the director of PRCH, facilitated this meeting. Prof Davison’s team organised a series of programs to introduce their recent research projects at PRCH. A few peer specialists met us to share their experience and described how they were able to make an impact on their clients’ recovery. Prof Davison reframed some of our questions to help the peer specialists answer with ease. He is a psychiatrist who genuinely values the contribution of the peer consultants and is willing to share his ‘power’ with them. They work in true partnership. Details of the CCEP are described in the ‘Research Challenges’ section.

d. Peer Support in Vancouver, Canada

i. Peer Support Program funded by Vancouver Coastal Health

The coordinator (a peer) of the Peer Support Program within the Vancouver Coastal Health explained the role of their peer support workers: to work with consumers on a one-to-one
basis to help them attain goals which have been identified and agreed during their meetings. To be qualified to work in peer support, one has to have ‘lived experience’ as a consumer, and training will be provided after recruitment. Peer support workers typically work part-time 5-10 hours a week (20-40 hours a month). Similar predominantly part-time employment is observed in Australia and the U.S.

While the peer support workers provide one-to-one support for other consumers to achieve their goals, they also perceive themselves as moving forward on their recovery journey, thus resulting in mutual benefits for both parties.

ii. Consumer Initiative Fund
There is another program called the Consumer Initiative Fund (CIF details are available on the website: Spotlight on Mental Health [www.spotlightonmentalhealth.com](http://www.spotlightonmentalhealth.com)) which is fully managed by consumers with the help of a program coordinator. The CIF coordinator talked about the different projects, which included the following:

a) Art studios bursary fund
b) Crisis fund
c) Education and leisure fund
d) Evergreen project
e) Tardive dyskinesia support group
f) Highs and Lows choir
g) Write from the heart

The CIF Committee meet weekly to discuss and monitor the progress of the projects. In these meetings, members support each other and apply problem-solving skills to any issues that have arisen. In terms of education and training for consumers, CIF aims to develop leadership skills, self-esteem, and interpersonal development, while sustaining the long-term recovery and wellness of its members. Although CIF is an innovative concept for consumers to utilise their talents and skills, it may also lead to inadvertently isolating themselves from the general community (is an art club exclusive to consumers a form of self-imposed social isolation?). IMF runs annual workshops and retreats for managers to discuss their challenges (e.g. how to break down stigma) and share strategies to navigate their way through their illness and the health system.

iii. Wellness Recovery Action Plans (WRAP)
Peer support workers who have received Wellness Recovery Action Plan (WRAP) facilitator training are contracted to run WRAP workshops to help consumers to develop individual WRAPs. All WRAP programs are facilitated by peer workers. There are also WRAPs for staff members to familiarise themselves with the program. Vancouver Coastal Health advertises the WRAP programs through their service and network. Many of the participants are self-referred.

iv. My Artist Corner, supported by the Canadian Mental Health Association
‘My Artist Corner’ or MAC ([http://vancouver-burnaby.cmha.bc.ca/services/crs/macis](http://vancouver-burnaby.cmha.bc.ca/services/crs/macis)) is an initiative of the Canadian Mental Health Association that has been active since 2005.
Consumers with different levels of art ability meet twice a week to share their passion for creative arts and learn to further develop their skills. Their mission is to

*improve the quality of life of adults with mental health issues, by creating a place that is safe, affordable, and welcoming for them to produce, display and sell art.*

The architects behind MAC believe that people with mental health problems can encounter many barriers that affect their ability to pursue their artistic talents (e.g. cost of materials, lack of space and difficulty in motivating themselves). The program provides members with the opportunity to learn new artistic techniques, sell their art, and connect with the general art community).

I visited a regular session and took part in the planning meeting for 2011. MAC has played an important role in many MAC members’ recovery. There is strong group cohesiveness and connection between members, which helps to lower their level of social isolation. Over the year, members have gained higher levels of self-confidence, improved ability to try new things, and have learned new skills (e.g. new artistic techniques and participation in the committee). Quotes from two MAC members in the MAC 2010 annual report:

*MAC has been helpful to me for making me more comfortable being around groups of people. My nerves are better when I’m painting, it makes me calmer.*

*I think MAC has really interesting and diverse art instruction. Being in company with other creative people helps me socialize and feel motivated to do art.*

These quotes reflect the impact of MAC on its members in their recovery journey. The dedication and commitment of MAC’s honorary coordinator (who is a consumer) has brought MAC to today’s stage. They are now planning their fourth series of greeting cards (each containing an image from a member’s creative art work). The money raised from selling these
cards to the public not only serves to break down any stigma but also is an important financial source to sustain MAC’s continued operation.

4. Chinese-Canadian Mental Health Services Providers

a. A Brief Assertive Communication Workshop at Yet Keen Chinese Seniors Day Centre in Ottawa

The trainer (right) and a participant were doing a role-play to practise assertiveness.

I had many emails and long-distance phone calls before all the details of the half-day Assertive Communication Workshop were confirmed. Registration was slow at the beginning. Apparently members of the Somerset West Yet Keen Chinese Seniors Day Centre were attracted more to health talks on physical illness. They were not familiar with the topic ‘assertive communication’. With the coordinator’s further explanation, enrolment jumped to 30 the day before the workshop.

On the day, I explained the interactive nature of the program: the more participants shared their everyday encounters in Ottawa, the more I could adapt the content of the workshop to suit their needs. After the ice-breaker activity and the fact that most participants knew each other quite well, trust was quickly established. One participant talked about recurrent frustrations at work that had impacted on relationships with other family members.

Participants were attentive to learn about how assertiveness could be applied in everyday life.
Another participant commented that it was wrong to divert anger towards other family members. I was quick to point out that all participants were invited to share their emotions and thoughts, and there was no ‘right’ and ‘wrong’ in their behaviours. It was not up to other participants to make a judgement. I had to make that clear at the beginning, so as to encourage everyone to share their stories in a safe environment.

Participants were given time to share their stories in small groups. They talked about incidents where they found their communication partners aggressive or they felt that they had been taken advantage of. I then invited participants to share their stories in a large group, and demonstrated how to apply assertiveness in those scenarios. (For example: An elderly person was not offered the health cover promised after health insurance was purchased).

I then talked about ‘assertive communication’ as a way to assert one’s rights and express one’s thoughts and emotions ‘matter-of-factly’. Putting it in Chinese idiomatic terms, it could be seen as a negotiation or bargaining technique. People could state their rights but also listen to their communication partner’s rights. Each communication partner would have to be prepared to negotiate and respect the other partner’s feelings and decisions. I also explained the Chinese traditional wisdom of practising assertiveness only with the right person, at the right place and also at the right time. On the other hand, assertiveness challenged the traditional Chinese hierarchy of power and authority. Although in the past Chinese seniors were automatically given authority over the juniors, in the 21st century this authority is challenged with ‘rights’ and ‘facts’. Workshop participants were well aware of this and no longer took for granted their authority, especially when dealing with their next generation who had grown up in Canada.

The role-play session was well received and the overall evaluation of the program was good. One evaluation question asked participants to nominate the most useful part of the workshop, and from the responses the session on ‘self-care vs selfish’ came first. In traditional Chinese teachings, ‘self-care’ is often given the lowest priority among Chinese women. Thus this was quite a new concept for the participants to grasp. Overall, this first Canadian chapter of the Assertive Communication Workshop was a success. I was encouraged by the willingness of the participants to share their not-so-glamorous stories, which resonated with the narratives voiced in Sydney workshops. There seems to be a huge potential for this kind of assertive communication program for Asian migrants residing in a predominantly Western society.

b. Chinese Mental Wellness Association of Canada, Richmond, Vancouver

The Chinese Mental Wellness Association of Canada (CMWAC) is a consumer-managed organisation in Richmond, Vancouver. According to the founder of CMWAC, Ms A Chin, over 60% of residents in Richmond are of Chinese background. It is worth mentioning that I did not hear back from Ms Chin after a few emails. I then learned from other mental health service providers that CMWAC was facing many challenges. As a consumer myself, I could understand the demands of running a consumer-managed organisation. With perseverance, I subsequently made a few long-distance calls to explain the nature of my proposed visit and confirm the details. I would share some stress management tips with their members in the format of a health education evening.
Despite the sub-zero weather, there was still a good turn-up on the day. Ms Chin told me the history of the association and the challenges she faced in terms of lack of government funding. I again invited audience participation from the very beginning. Members could be actively involved and could share their views and tips on stress-management with each other. One person talked about taking the driving road-test in Vancouver. Positive self-talk helped boost that person’s confidence to relatively calm and get through the test. Another parent with teenagers talked about reasons why many Chinese migrants were hesitant to ask friends for urgent help (e.g. fear of rejection). Most migrant families had stretched their resources and were unable to offer much help, even though they would wish to do so. Perhaps people should try to respect whatever answer they might get from their friends, even though it could be negative at times. I thanked this participant for such insightful ideas. With participation in organisations like CMWAC, it is hoped that Chinese migrants in Richmond would have access to more community resources.

It was encouraging to find so many young volunteers, male and female, at CMWAC helping out with the administration, provision of information and web-site maintenance. There is an increasing demand for mental health information and services in an area like Richmond. Thus the services offered by CMWAC (including recovery-focused support groups, mental health talks, art and other leisure activities) are extremely valuable. The challenges they faced are not easy to overcome:

1. Scepticism about consumer-run organisations
2. Fund raising
3. Volunteer recruitment
4. Media promotion
5. Collaborations with professional service providers

However, with Ms Chin’s passion and her exceptional leadership, I believe the continuing effort in advocating for more culturally sensitive mental health education and peer support will eventually pay off.

c. Canadian Mental Health Association (CMHA) Vancouver-Brunaby Branch

On my first visit to CMHA I participated in a ‘Heart to Heart’ support group for consumers and family members facilitated by a volunteer in Cantonese. The facilitator is a family member and has been a dedicated volunteer for some years. The first half of the meeting (45 min) was a mental-health related talk which the facilitator prepared in advance. In the second half, the facilitator opened the floor for discussion. The facilitator gave some feedback after each member’s contribution.

After talking to the Chinese migrants at the three Chinese-Canadian organisations, I identified some common triggers for their stress or emotional distress:

- Intergenerational conflicts
- Harsh comments about poor English language skills
- Effort not being translated into positive outcomes
- Transportation out and about being very challenging
- Feeling like third or fourth class citizens
- Unemployment or under-employment
- Everyone’s resources being stretched to the limit, with reluctance to seek help from friends (even close friends) so as not to burden them
- Negative emotions and feeling of depression still being very much a taboo subject, and thus often being bottled up
- Even when negative emotions are voiced with loved ones or close friends, the person is seldom given the empathy needed. Instead s/he is bombarded with solutions to solve the problems.

My brief observations of the everyday life of Chinese migrants in Ottawa, Richmond and Vancouver bore some similarities to the narratives I collected in my research undertaken in Sydney (Chan 2007). There is a significant demand for migrant mental health services in Canada. The Yet Keen Seniors Day Centre is a good platform for mental health promotion and mental illness prevention. The Chinese Mental Wellness Association of Canada, a consumer-run organisation, is already using a ‘recovery-framework’ to reach out to Chinese of all ages and has been successful in recruiting volunteers to assist with running their programs. By volunteering, their members could develop their skills and boost their self-esteem and find positive meanings for themselves and a sense of belonging to the community. These are some basic values recognised by the recovery framework. CMHA is a well-established organisation providing a variety of high quality services (e.g. support groups, health talks) to the Chinese community. With more resources, they could strengthen the training for their volunteers and peer support workers, which would undoubtedly advance their services to even higher level.

**d. Canadian Mental Health Association – Challenges in securing funding for recovery-focused services for the Chinese community.**

Securing long-term rather than sporadic funding has been an ongoing challenge. Another challenge is to redesign and re-invent service models that cater for cross-cultural rather than ethnic-specific health services. In my visit to the Canadian Mental Health Association and talking to Ms Kwok (Resource Development Coordinator), I learned that it has been increasingly difficult to obtain funding for ethnic-specific (e.g. Chinese) service programs due to a change of focus to cross-cultural disciplines and services among the funding bodies (e.g. Vancouver Coastal Health).

One example of a service offered by CMHA is ‘Volunteer & Partnership’, which has been running for about 17 years. A client is matched with a volunteer in terms of interests and leisure, and resources on a one-to-one basis. A stringent screening process is in place to conduct the matching. The volunteer can be someone with or without lived experience of mental illness. After matching, the volunteer works with the client on many different programs, such as recreation, leisure, employment and rehabilitation.

Ms Kwok questioned the feasibility of providing services to cater for diverse groups with various English competencies and very different cultural practices. I shared with her the dialogue I had with the researchers at the Yale Program for Recovery and Community Health. Since the recovery-focused service paradigm inherently embraces diversity and respect for individual differences in cultural and spiritual practices, ideally service users coming together
at various point of their recovery journey could work together to achieve their own personal goals, with the help of peer consultants and staff. The support for each other and the sharing of their lived experiences as mental health service users could be their common ground. Provided the participants have basic mastery of the English language, theoretically the objectives of this kind of recovery-focused programs should work. It would be a bonus if there are bilingual peer consultants among the staff who could speak the same language and identify with the same cultural values as the service users.

This kind of service model takes away the pressure for service providers to develop programs for specific ethnic communities, and encourages all staff members to learn some generic cultural competency skills to be more sensitive in addressing the needs of clients from diverse background (e.g. South Asians, Chinese or Gays & Lesbians). Whenever new service models are proposed to the funding bodies, scepticism as to their efficacy would be expected. Perhaps researchers could collaborate with service providers and service recipients to evaluate new service models. I have been advocating such inter-sectoral research partnership in my own work (Chan 2009).

III. Research challenges?

1. Are randomised controlled trials the gold standard of medical and health research?

Are randomised controlled trials (RCTs) the most suitable method to evaluate a complex new community mental health service model? This question has been in my mind since I first applied for funding to run the pilot Assertive Communication Program from ‘beyondblue’. Jewel et al (2006) pointed out that due to policy makers’ increasing interest in evidence-based medicine, RCTs have gained much popularity and acceptance within and outside the health community as the gold standard of evidence. For that reason, many evaluations of health-care programs and public mental-health policies are driven by quantitative data obtained using RCTs. However, the RCT design paradoxically sets a very high level of evidence of success that is hard to achieve in community-based research settings. The study conducted by Jewel et al also illustrated an ethical dilemma: frustration was experienced by peer specialists as some services (after engaging their clients to complete the baseline interview) had to be discontinued after consenting participants were assigned to the control arm of the RCT. These participants were those who most needed services. Perhaps one could argue for a ‘wait-list’ design for clients in control groups. However, a waiting period of 12 months would still be unreasonably long to withhold a service.

During my visit to the University of Ottawa, Dr Bill Hogg (Director of the C.T. Lamont Primary Health Care Research Centre) spent much time helping me with a sound research design for the next phase of a study to further evaluate the efficacy of the Assertive Communication Program. He emphasised the importance of separating the different components of the program which were most effective, since it was a multi-faceted intervention. The immediate challenge is to recruit enough sub-groups with adequate numbers
of participants to ensure that statistical power can be reached. This kind of service evaluation research is labour-intensive; there is not only the actual running of the program, but also engaging and retaining participants for data collection at different time points, a baseline, an intermediate and a final survey. The initial recruitment must take into account potential drop-outs during the research.

Yet another challenge is that participants’ lives can be very complicated, unlike a well-controlled setting in a laboratory. Having learned a new skill (i.e. assertive communication), participants are likely to show minimum change initially, then they might have to wait for the right opportunity or context to test their skills. Hopefully they will improve with practice and perseverance. It is also common for their skills to plateau at a certain level. Dr Hogg was particularly interested in how assertive communication would have an impact on newly arrived migrants. In terms of mental health promotion and long-term planning on multicultural health services, early intervention to facilitate migrants’ social integration has obvious benefits in future health expenditure. Dr Hogg also recommended a mixed method approach to pin down causality. It would be wise to collect a comprehensive profile of participants’ demographics, including details of family structure, to allow for regression analysis.

During this study tour I presented the pilot findings of the Assertive Communication Program to researchers and service providers in Ottawa, Montreal and Washington DC. I received encouraging feedback, and some service providers were keen to find out how this program would be accepted by younger and more acculturated (Westernised) participants. The programs so far have attracted mainly middle-aged to elderly Chinese migrants who were at the lower end of acculturation. I explained that a branch of the current project was to test the feasibility of an equivalent program available on the Internet, with or without the face-to-face role-play component. The initial feedback I have gathered is that the program’s success seemed to build on the role-playing which allows ample opportunities to rehearse and practise assertiveness in a safe and controlled environment. Questions were also raised on the subject of expanding the program to non-Chinese migrant communities, with appropriate adaptation. I have conducted one program in English with a mixed group of Chinese and Korean personal care workers. The Korean participants rated the program as helpful. However, I see the need to involve Korean participants in exploring their culture more deeply and adapting the content of the role-play to reflect their customs and practice.

2. Could community-based participatory research in health be a viable alternative?

I visited Prof Ann Macaulay, the Director of Participatory Research at McGill (PRAM), to gain some insight into an absolutely ‘bottom-up’ research methodology which involves the participants from the conception of the research to explore a pressing concern or some health questions of the researched population. Embedded into the participatory research process is integrated knowledge transfer, which means that ‘evaluation and action’ are on-going. It is beneficial and necessary to document each step of action being taken, and to involve those who need to act on the outcomes as partners throughout the research process. Hopefully, it
will also lead to developing valid knowledge that is applicable to other settings. According to the mission statement from PRAM’s website: ‘Participatory Research is an approach to conducting research where researchers are in partnership with the intended users of the research – which may be patients, health professionals, organizations, policy makers, community members or entire communities.’ (http://pram.mcgill.ca/). Professor Macaulay gives the following advice to a beginner participatory researcher like me:

1. Set down clear, simple guiding principles to define the roles of all members in the research partnership.
2. The initial research questions could be initiated by the researchers but the final priorities of the research topics would be shaped through the consultation process.
3. The team could include the researchers, knowledge users (community where research is undertaken), service providers and policy makers.
4. It is important to establish trust between the research partners and acknowledge the power differentials between the different partners.
5. Establish an understanding of where everybody is coming from, the reasons behind their involvement, and the goals they want to achieve.
6. It is necessary to acknowledge barriers and inherent conflicts due to the different perspectives of the partners.
7. Allow adequate time to communicate openly during the consultation (meetings) and don’t make hasty decisions.

A relevant application of participatory research would be to develop the E-assertiveness program targeting younger and more acculturated second generation Asian-Australians (i.e. children of overseas-born Asian migrants).

3. Link between peer-led recovery-focused services ‘Citizenship and Community Enhancement Project’ (at PRCH in New Haven) and the Assertive Communication Program (in Sydney)

It seems that I have come up with more questions than answers from my visits to the top research centres in Montreal and New Haven. It was a valuable learning experience to stimulate deeper thinking into how best to move forward the research of the Assertive Communication Program. The relevance of the Recovery Paradigm to my research was the fact that the recovery-focused service framework embraces diversity and respect for differences in cultural practices and spiritual beliefs.

Rowe et al (2009) propose three levels of citizenship in their research into homeless Americans with mental health issues and possible criminal justice histories:

1. Full citizenship
2. Second-class citizenship
3. Non-citizenship

Most migrants consider themselves second class citizens due to language barriers, social isolation, racial discrimination and unemployment (or underemployment), whereas
individuals with severe mental illness often fall into the non-citizenship category. They are marginalised by the mainstream who treat them as ‘the scum of society’. The citizenship community enhancement program mainly equips them with life skills, skills of relationship building, assertiveness, stress management, public speaking and vocational and educational development (for details see http://www.yale.edu/PRCH/research/comm_enhancement.html). The best outcomes one could expect are that these people can exercise their rights and fulfil their responsibilities as citizens while having social resources and meaningful relationships within their community. Students in the project also learn to explore their social roles, to recognise and put into practice behavioural changes that will help them to enhance their roles. Most importantly, they regain respect from fellow citizens as valued members of society.

The following are some quotes from students who have graduated from the 5-month program:

\[\text{This group has made me realize that I have good qualities and I can contribute greatly to my community.}\]
\[\text{This program gave me a lot of valuable information and some of it helped me find a home. I’d been homeless almost four years.}\]
\[\text{This program has given me structure, confidence, love, support, positivity. Me!!!}\]

**Link between recovery and assertive communication**

When I read the recovery narratives for people with mental health issues, I wondered whether Chinese migrants are dealing with recovery socially. Having been uprooted from their heritage culture and disconnected from their social network, these migrants need to work hard to ‘recover’ from their loss. Fitting this social recovery process into the Citizenship Theory’s 5 Rs (rights, responsibilities, roles, resources and relationships), these migrants come to the Assertive Communication Program to not only learn to assert their rights but also to master the other four Rs. Every participant who attended my previous workshops had a personal narrative. Was this the subjective aspect of recovery in relationships? It might be the inter-generational relationship changes due to values and traditional cultural beliefs being challenged by a second generation brought up in Western education, or it might be the couple relationship readjusted as a result of unfavourable employment circumstances. What about relationships with colleagues (immense frustrations at work) due to language barriers and lack of recognition of qualifications and overseas work experiences? These were just a few examples of the narratives voiced in my pilot program.

How does migration have an impact on someone’s life? What things need to be changed outside the person to achieve a full life of recovery in the sense of regaining full citizenship in society?

In a conversation with A/Prof Michael Rowe of PRCH at Yale University, he talked about how the recovery framework is centred on a strength perspective; it focuses on the person’s strength, the hope that one can see in one’s future. How to look for jobs and further education, to overcome personal challenge and to post a political statement? How to send a signal to others that ‘I am just one of you even I speak English with an accent and I am not white’? How to access resources to achieve one’s recovery or reach a form of solidarity with the people around?
Again, questions needing further exploration are ‘Does the self-perceived sentiment of being a second class citizen include not having a …

- sense of belonging
- sense of acceptance
- sense of participation
- sense of having a value-role in society?’

Could assertiveness training help Chinese-Australians to establish a sense of belonging in Australian society? Do people really want to belong to Australian society? Do they really want to integrate? Or simply they are happy to trade-in their rights for respect? To say:

*Even though I have my own culture, I still want to feel that I’m respected and accepted.*

Assertiveness training may help interaction between Chinese and Australians. It may in fact start chipping away racism. Racism often breeds from ignorance. Chinese migrants cannot wait for ALL Australians to become friendly. Assertiveness can help migrants build self-esteem and self-confidence: *knowing how to negotiate my way.* They can feel that they are on an equal footing with other Australians during cross-cultural encounters. The challenge for me is to provide sufficient evidence to prove that my Assertive Communication Program can achieve the following for participants:

- a) to develop a meaningful relationship with the wider Australian society,
- b) to demonstrate a significant decrease in acculturation stress
- c) to gain knowledge about available resources
- d) to assert citizenship rights
- e) to fulfil citizenship responsibilities
- f) to feel respected by the people around and play a valued role in society

Another research question worth further exploration is whether there will be any difference if the Assertive Communication Program (Chan 2010) is facilitated by a peer or a non-peer? This will be an important aspect to explore, whether or not the lived experience of having gone through the ‘social recovery’ will have the ‘added value’ of allowing rapid engagement with the participants and gaining their trust. This is crucial when one considers that the duration of the program is only 7 weeks.

**IV. Recommendations:**

The 6 weeks of my Churchill Fellowship in North America were truly inspiring. This report is more than a record of what I have seen or learned, it is a testimony to the peer workers’ contribution to recovery-focused mental health services. I hope to highlight the key messages I took home and see how they can be applied in the Australian context. My recommendations are summarised below:
1. Recognise the contribution of peer consultants to mental health services and provide them with the necessary training, support and career development

Training, supervision and continuous professional development are paramount to sustain the contribution of the peer workforce. As with any other profession, gaining recognition from colleagues in related fields is the first hurdle. Initial scepticism is not uncommon, and doubts will exist about the competence of these consumers-turned-experts, concern about their own vulnerability and likely relapses, the dilemma of working as a ‘paid peer’ especially in maintaining professional boundaries.

The peer counsellors at Kings County Hospital Center in Brooklyn have already brought about a change of culture among the mental health workforce. They proclaim proudly that ‘Recovery works, we are the evidence!’

Having overcome inertia, the next step is to keep the ball rolling; otherwise the momentum could soon die down. In is very important that these peer counsellors/specialists are given adequate training before they are sent to the front-line.

The ‘added value’ of the peer workforce lies in the fact that they may have first-hand experience of many mistakes or failures in their journey of recovery. They can empathise with their clients and interact with them with minimal power disparity. These are the essential ingredients for establishing rapport and trust. Regular supervision and continued professional development can help the peer workforce to further advance their skills and win over the sceptics. Hopefully, with increasing recognition of their work, with more peer positions being created and with the workforce expanding steadily, they can negotiate for better financial remuneration.

2. Explore the concept of citizenship in recovery-focused service development for culturally and linguistically diverse communities – what does it mean to once again become a productive member of society?

If a consumer from a culturally and linguistically diverse background uses the argument ‘entitlement to basic medical services is a human right’ to advocate for better mental health service, this may inadvertently corner the people s/he is dealing with, leaving them no leeway to manoeuvre. The 5 Rs (Rights, Responsibility, Roles, Resources and Relationships) of the citizenship concept taught at the Citizen Community Enhancement Project, Yale Program for Recovery and Community Health, encourage individuals not only to assert their rights as citizens, but also to accept their responsibilities (being law-abiding and tax-paying). By being an active member of society, people develop meaningful relationships and seek out existing community resources. By completing a valued-role project, people can become part of the resources (i.e. productive members of society). Eventually these citizens will enjoy well-earned respect without having to beg for it (even though one could easily argue that respect is a basic human right).
By the same token, the pilot Assertive Communication Program has taught Chinese migrants these 5Rs. The pilot results were very promising. With further development of this program, applying the citizenship theory, more migrants will acquire full citizenship and enjoy sound mental health.

3. Support consumer advocacy among CALD communities; advocacy is exhausting and need continuous support.

Imagine a global alliance of mental health consumers sharing their tremendous effort in advocating for their citizenship rights (and responsibilities) and high quality mental health services. Throughout the trip, I experienced moments of ‘instant connection’ when the peer workers learned about my peer status. This triggered my thoughts about a global alliance of consumers. Wouldn’t it be wonderful if consumer-managed organisations could join forces to share information, resources and inspiring stories? Wouldn’t it be fantastic for someone from CMWAC to apply for funding from the Consumer Initiative Fund (CIF) to attend the Washington DC Conference? Consumer advocacy is challenging, as consumers are all at different points of their recovery. Advocacy is exhausting because you are constantly banging your head against a brick wall. Every now and then, you’ll want someone to pat you on your shoulder and say ‘It’s OK, you’ve done a great job, just hang in there and don’t give up!’ This follows the recovery paradigm of first and second order changes: when consumers are confident about changes in their own recovery, they may connect with other consumers in recovery to pursue second order change.

4. Foster international research collaboration and partnerships

What impact does globalisation have on medical research? Improved communication technologies and the invention of the Internet have made it possible for research teams from different parts of the world to share ideas and establish multi-sites and transnational research collaborations. An obvious advantage is that researchers with similar mindsets can pool their resources to collaborate on a research project rather than duplicating their efforts at opposite ends of the planet. Such collaboration encourages exchange of ideas and utilisation of each research partner’s expertise and strength. The ultimate benefit to the people of this world is a higher standard of medical services and better understanding of different aspects of human survival.

During the Fellowship tour I was privileged to be able to visit some top research centres in Canada and the U.S. Even at an earlier stage of the Churchill application, when I wrote to the various organisations, I could feel a sense of synergy. It created so many possibilities for future collaborations. I have long been thinking about taking the Assertive Communication Program abroad to test its relevance to Chinese migrants in other parts of the world. Applying the theory of citizenship with the Assertive Communication Program seems to be an ideal partnership. Since my return to Sydney I have been actively pursuing application for an Australian Research Grant Linkage Project and inviting Yale’s researchers at PRCH to be a partner organisation. All these research collaborations are challenging but exciting.
5. Develop inter-sectoral collaboration to expand community mental health programs

It is crucial to foster inter-sectoral collaboration between various services to make it more user-friendly for migrants to navigate through the mental health system and to access urgently needed services. Services have been working in silos for too long. Collaboration requires a champion with foresight to come forward to lead the team, to be prepared to take it out of the ‘too hard basket’. I worked exceptionally hard to collaborate with ‘beyondblue’ (the National Depression Initiative), the Chinese Australian Services Society (CASS) and the research centre (Centre for Primary Health Care and Equity, University of New South Wales) where I was based, to make the Assertive Communication Program a reality in 2009.

During my tour I was excited to hear many more stories about inter-sectoral collaborations, especially those involving community stakeholders. Our modern life has evolved to be so complex and professional expertise has become so specialised, that addressing mental ill-health is no longer the sole business of the medical specialists. Multidisciplinary teamwork that involves the patient, peer consultants, psychiatrists, family doctors, psychologists, social workers, nurses and family members is a sound concept. Each member of the team contributes their expertise to help patients on their recovery journeys. Undoubtedly, peer consultants play the role of an ‘expert patient’.

6. Create innovative service models to cater for both men and women

The gender divide is not new. Women are more willing to seek help while men seem to be more reluctant to disclose emotional distress. This leads to the need to develop gender-specific models (such as the Women’s Resource Centre at the Institute of Mental Health Research in Ottawa or Mensline Australia [http://www.menslineaus.org.au/]). Support groups seem to work well for women because traditionally women have enjoyed getting together to do art and craft while having a chit-chat. New service models like ‘Men’s Shed’ where participants are under no pressure to talk about their issues, are welcomed by men. Their primary objective is for ‘men to gather together and/or work on meaningful projects at their own pace, in their own time and in the company of other men to advance their health and well-being’. On their website ([http://www.mensshed.org/page7859/Home.aspx](http://www.mensshed.org/page7859/Home.aspx)), the gender difference is nicely summed up in the slogan ‘Men don’t talk face to face, they talk shoulder to shoulder’.

The same applies to migrants: men are likely to feel a greater impact of unemployment or under-employment than women; women on the other hand may be more troubled by social isolation. But if a program can attract both men and women, it will provide an opportunity for them to understand and empathise with the opposite sex. This may in turn build stronger relationships within the nuclear family or the extended family, an imperative for many migrants as their social resources are usually less plentiful after their migration.

I also recommend the innovative yet pragmatic approach in running a program that is suitable for all ages and both genders (e.g. the Assertive Communication Program, and the Media
Room at KCHC). Through their activities, users of these services establish meaningful relationships with each other, paving the way for their recovery.

**Conclusions**
The Churchill Fellowship has provided me with a very valuable experience. I feel honoured to have been able to visit the top research centres in North America. The passion and enthusiasm of all the peer workers I met during the six weeks are overwhelmingly inspiring. While they help their clients move forward in their recovery, these peer workers are helping themselves to advance further. I am glad to see that Australia is endorsing the strength-based recovery framework in the Community Mental Health Program. This also leads to the need to evaluate the efficacy of these peer-led mental health services. Collaborations with researchers in North America, who are more advanced in this kind of program evaluation, will certainly benefit Australia and ensure that high standards are achieved. I certainly hope my report will present a consumer-researcher’s perspective to peer-led mental health services within the recovery paradigm. Most importantly, the Churchill Fellowship has formed part of my recovery journey.
References:


