Mental Health & Substance Abuse Division

The Framework for recovery-oriented rehabilitation in mental health care

2012

South Australia will have a recovery-oriented mental health system that supports individuals' unique and personal journeys to wellness. This will be achieved by providing holistic, recovery-oriented, evidence-based rehabilitation services in which service providers work collaboratively and with due regard for the expertise of the individual, their carers and their families to support each person's recovery journey.

[Vision Statement]

Government of South Australia
SA Health

Table of contents

Abbreviations

CALD	culturally and linguistically diverse
CBT	cognitive behaviour therapy
CMHC	Community Mental Health Centres
CNAHS	Central Northern Adelaide Health Service
COAG	Council of Australian Governments
CPGRR	Core Planning Group for Rehabilitation and Recovery
CPI	clinical practice improvement
CRC	Community Rehabilitation Centres
ICC	Intermediate Care Centre
IPRSS	Individual psychosocial support services
NGO	Non-government organisation
PRSS	Psychosocial Rehabilitation Support Standards

Preface

Good mental health and wellbeing makes a vital contribution to the overall health and wellbeing of individuals and our communities. It influences social and economic outcomes for South Australians of all ages and cultural backgrounds.

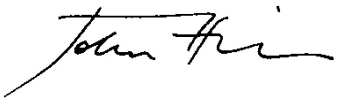
The Government of South Australia is committed to helping all South Australians achieve the best possible mental health by providing a recovery-oriented mental health system that supports individuals' unique and personal journeys to wellness. *The Framework for recovery-oriented rehabilitation in mental health care 2012* describes how this will be achieved by providing holistic, recovery-oriented, evidence-based rehabilitation services in which service providers work collaboratively and with due regard for the expertise of consumers, carers and their families to support each consumer's recovery journey.

The Framework is underpinned by a recovery orientation that focuses on individuals' unique strengths, resilience and capacity to grow and change. While recovery is owned by and unique to each person, mental health rehabilitation services that are recovery-oriented play an important role in creating environments that facilitate and support a person's own personal recovery journey. Mental health rehabilitation services aim to support a person to create a fulfilling, hopeful and meaningful life and to achieve his or her own aspirations, despite the difficulties or limitations that can result from the experience of mental illness.

A recovery orientation to practice ensures a focus on consumer experience of care and a commitment to right service at the right time in the right place. The Framework supports South Australia's Strategic Plan Target 2.7 to improve psychological wellbeing. It also builds on the significant investment made by the Government of South Australia to implement the strategic reforms set out in *Stepping Up: A Social Inclusion Plan for Mental Health Reform 2007-2012* (2007) and the *Review of Community Mental Health Services in South Australia* (2008).

This Framework recognises the importance of a collaborative partnership approach to the provision of mental health care. It provides a solid foundation of shared understanding and best evidence to consolidate and extend linked rehabilitation services. It also includes a commitment to the ongoing development of partnerships with people who experience mental illness, their carers and families, government and non-government sector organisations and the general community, to promote positive mental health and provide the best possible mental health care for all South Australians.

I hope that all South Australians will support the directions set out in this Framework and continue to contribute to the whole of community effort to promote good mental health and wellbeing in South Australia.



HON JOHN HILL MP

Minister for Health and Ageing
Minister for Mental Health and Substance Abuse
Minister for The Arts

Executive Summary

Mental health services in many parts of the world are undergoing significant reform in relation to structure, services and approaches to service delivery. South Australia's current reform agenda is no exception and change is occurring at a rapid pace. The reform agenda is multifaceted, the core of which is a 'recovery orientation' (described in detail in section 4 p19) that drives a shift to the development of seamless service provision that is consumer centred, accessible, flexible and responsive to the needs of consumers and their carers. The international and national experience of recovery-oriented practice has provided the evidence-base underpinning best practice in mental health services. A recovery orientation to practice ensures a focus on consumer experience of care and a commitment to right service at the right time in the right place.

State and national policies clearly state that all mental health services should be recovery-oriented and services delivered should be based on supporting a person's own unique and personal journey to create a fulfilling, hopeful and contributing life and achieve his or her own aspirations, despite the difficulties or limitations that can result from the experience of mental illness.

There has also been a shift towards the development of more rehabilitation services in South Australia. Given this move, it is timely that a rehabilitation and recovery framework clearly articulates the principles of rehabilitation and recovery and promotes a shared understanding of recovery-oriented rehabilitation services.

This document provides a foundation of shared understanding about rehabilitation and recovery and how partnership between all stakeholders will enable the further development of mental health services in South Australia that are person-centred, strength-based, community-orientated and offered within the collaborative relationship in which power is shared between the person and the practitioner.

Understanding the relationship and connectedness between recovery and rehabilitation is pivotal if service provision is to truly adopt and integrate this paradigm shift. Clarity will also assist with the ongoing development of collaborative partnerships with consumers, carers and services, the public, private and non-government sectors.

Representatives from mental health services throughout the different sectors and regions of South Australia, consumers, carers and the non-government sector have joined together to form the Core Planning Group for Rehabilitation and Recovery (CPGRR) and driven the process of formulating this document. Wide consultation around this document has been undertaken by the CPGRR through workshops, individual and group consultation and surveys. This framework builds on the work that has been done to transform mental health services in SA and brings together in one place this work, current research and thinking, and looks holistically at mental health services in South Australia.

Following the release of this framework an expanded CPGRR will form and will focus on the implementation of this framework and the drafting of a plan to improve rehabilitation services across South Australia. The plan will go to the Statewide Mental Health Executive for approval and endorsement and will include training and professional development and practice development and consistency of practice as a starting point.

Key Messages

Context

- South Australia's mental health system is undergoing significant recovery-oriented reform.
- The Stepping Up report, which has been a pivotal platform for South Australia's current reform agenda, is a starting point; however, it does not describe all rehabilitation services available to consumers of mental health services in South Australia.
- The NGO sector has grown substantially and is a key provider of mental health services in SA. This has resulted in an increase in the rehabilitation services available to consumers.
- Publicly funded government mental health services are reforming their systems and services to better meet the needs of consumers. It is vital that recovery-oriented rehabilitation services also continue to be available and grow in the publicly funded government sector. Models of care and guidelines are important in implementing this change.

Recovery

- Recovery is personal and unique.
- People can and do recover from mental illness.
- 'Recovery' and 'cure' do not mean the same thing. People can and do live well with the presence of symptoms of mental illness.
- Recovery is supported by collaborative partnerships in which key partners develop facilitative relationships to meet the individual consumer's needs.
- Health workers must embrace the potential for recovery in their approach to practice.
- There is no time frame set for an individual's recovery journey. Everyone's recovery journey is unique.
- Recovery is not an intervention and professionals cannot 'do' recovery 'to' people.

Rehabilitation

- Best practice rehabilitation is recovery-oriented.
- Recovery is the potential and actualisation of person's individual journey.
- Rehabilitation is the process and the tools that practitioners utilise and provide to people to assist in their recovery journey.
- Rehabilitation should be available in all settings and begin as soon as possible.
- Rehabilitation practices should always encompass purposeful evidence-based best practice interventions.
- Rehabilitation techniques provide a range of tools that can be used to assist an individual to gain/regain their independence and strive towards their recovery.
- Rehabilitation occurs on a continuum. All workers need to understand rehabilitation but not everyone needs to be an expert in providing all interventions.
- Rehabilitation enables people to connect and become part of their community and be satisfied and successful in the living, working, learning and social environments of their choice.[1]
- People with lived experience of mental illness and their carers should be key collaborators in the development, implementation, evaluation and modification of individual and group rehabilitation programs.
- The process of establishing a positive therapeutic relationship is a part of the rehabilitation continuum. It takes effort and time.
- Rehabilitation requires effort and engagement. Although it may not 'just happen' it rewards both consumers and practitioners.
- Rehabilitation will not necessarily lead to consecutive gains for each individual. Setbacks and overcoming setbacks are part of the rehabilitation process. Rehabilitation opportunities should be offered time and time again.
- Rehabilitation services that are shaped by goals of promoting hope, healing and empowerment ensure mental health services foster an underlying attitude that recovery is possible, offer opportunities for people to maximise their own experience of recovery, and create a service environment that is flexible, responsive and accessible.
- Rehabilitation is cost effective and reduces requirements for acute interventions.

Recovery-oriented rehabilitation workforce

- All workers who work in mental health need to understand the principles of recovery-oriented rehabilitation.
- All clinicians working in mental health have generic clinical skills as well as discipline specific knowledge.
- There are different roles within mental health services requiring varying levels of rehabilitation intervention knowledge.
- All workers need to be aware of the potential impact their approach to service provision can have.

Meeting everyone's needs

- Different populations have different needs and particular consideration must be given to how best to meet these diverse needs.
- No one service or person can cater to everyone's needs all of the time, however, mental health services must be culturally inclusive and responsive.
- It is vital that services work together in partnership to meet the needs of consumers, their carers and families.
- Country health services provide services to approximately thirty percent of the population in South Australia.
- Effective communication between services, consumers and carers needs to take place by a variety of means to meet everyone's needs (face-to-face, with interpreters, written communication, teleconferences, telephone, etc.).

Partnerships

- The consumer is the most important person in the partnership. They and their recovery needs must be considered first.
- Sharing information is essential. The rights of each individual need to be considered when sharing information.
- It is important that the role of each partner involved in care is clearly defined and understood. All partners need to assume responsibility for ensuring smooth coordination of care and everyone needs to be able to contribute.
- Carers are an important part of partnerships and need to be considered and included whenever appropriate.
- The process of establishing partnership is as important as the outcome.
- Partnerships should exist to empower consumers, create enabling opportunities for recovery and promote the consumer's dignity of risk.
- The partners are determined based on the needs of the consumer.

Safety and Quality

- The National Standards for Mental Health Services 2010 are applicable to all mental health services throughout Australia.
- Recovery orientation is expected and as National Standard 10.1
- All services have to perform to standards, and services are measured against these.
- Best practice is about how to continuously improve services. Feedback from partners, particularly consumers and carers, is vital in assisting to improve services.
- Supervision and reflective practice are fundamental concepts that underpin the provision of quality recovery-oriented rehabilitation services. Every worker should have access to regular supervision.
- Quality and safety are everyone's responsibility and need to be integrated into everyday practice.
- Additional research is required to ensure best practice around recovery-oriented rehabilitation remains up to date.

1 Introduction

1.1 Aims

The aims of this document are to:

- Describe the concepts of 'recovery' and 'rehabilitation', their interconnection and application across public and non-government mental health services in South Australia.
- Develop a shared understanding of the application of the concepts of recovery and rehabilitation to:
  - improve the way mental health services work with and provide services to consumers and carers
  - facilitate partnerships within, across and between mental health services, consumers, carers and other key stakeholders
  - describe the elements necessary for the transformation and improvement of mental health services in providing recovery-oriented, consumer-centred rehabilitation services
  - promote a shared vision for recovery-oriented rehabilitation services by describing consistent, person-centred, goal-focused and value-based practices
  - guide future policy-making, service-planning and implementation.

1.2 Vision

South Australia will have a recovery-oriented mental health system that supports individuals' unique and personal journeys to wellness. This will be achieved by providing holistic, recovery-oriented, evidence-based rehabilitation services in which service providers work collaboratively and with due regard for the expertise of the individual, their carers and their families to support each person's recovery journey.

1.3 Target audience

This framework has primarily been designed for service providers who work in mental health settings, including, but not limited to: clinicians, psychosocial rehabilitation workers, experts with lived experience, managers, private health services, health planners, general practitioners, and relevant government departments. It is also expected that consumers, their families and carers will access and use this framework, as well as the framework being used to guide policy and service-planning and implementation.

Table 1: Framework Utilisation Guide

Target group	Potential uses for the framework
Staff working in a recovery-oriented rehabilitation-specific setting	Provide a 'how to' guide to ensure they are working within the principles of recovery and rehabilitation Advocate for a more recovery-oriented rehabilitation service An information-sharing document to assist with the development of effective partnerships A conversational tool to promote and/or ask questions about how well the service keeps consumers at the centre of their recovery-oriented care Gain a shared understanding of the recovery-oriented language in service provision A guide to ensure appropriate service provision for consumers at any point of entry to services Evidence supporting the provision of recovery orientated rehabilitation services
Staff who work in other services	Increase knowledge about recovery-oriented rehabilitation services and what they may look like at different stages along the rehabilitation continuum Gain a shared understanding of the language used by recovery-oriented rehabilitation providers and the core business of rehabilitation service providers Use as a guide to ensure appropriate services for consumers at any point of entry to services Use as a resource to access specific information about recovery-oriented rehabilitation services as required
Senior staff who work with a recovery-oriented rehabilitation focus and managers of mental health teams	Use within supervision and training as an informative tool to assist discussion and a shared understanding about rehabilitation and recovery, and how these concepts fit together Ensure that every team is aware of the role their team can play in supporting an individual's recovery Assist with the development of partnerships between services
Managers of services	Advocate for the resources required to provide consumer-centred, recovery-oriented, evidence-based rehabilitation services Advocate for resources available to undertake further and ongoing research into evidence-based rehabilitation services
Policy writers	An informative tool Assist to advocate for increased recovery-oriented services Inform planning initiatives
Consumers	A guide to understanding recovery-oriented rehabilitation services An advocacy guide for ensuring consumers' needs are appropriately met
Carers	A guide to understanding recovery-orientated rehabilitation services
Private mental health practitioners	Gain a shared understanding of the language used by and the core business of recovery-oriented rehabilitation providers Use as a guide to ensure appropriate intervention for consumers at any point of entry to services Use as a resource to access specific information about recovery-oriented rehabilitation services as required
General Practitioners and primary health staff	Gain a shared understanding of the language used by and the core business of recovery-oriented rehabilitation providers Use as a guide to ensure appropriate intervention for consumers at any point of entry to services Use as a resource to access specific information about recovery-oriented rehabilitation services as required

1.4 The need for an overarching policy framework

The Framework for recovery-oriented rehabilitation in mental health care 2012 is designed to be used to guide service delivery with a focus on ensuring that people receive the right mental health services for their needs, wherever and whenever they are required. The framework provides a guide to ensuring recovery-oriented rehabilitation policy and service development, planning and implementation in mental health services. The framework will also provide a shared language and understanding of recovery and rehabilitation and how these concepts fit together in a service context.

The framework assumes a commitment at policy and service levels to the implementation of recovery-oriented rehabilitation services throughout South Australia. This will maximise opportunities to mitigate fragmentation of service delivery and to link the various aspects of rehabilitation services to promote continuity of care across both public and non-government mental health services. Ultimately, it will enhance service experience for people with lived experience of mental illness, their families and carers.

The framework is not designed to be a manual that dictates how rehabilitation and recovery should be implemented.

1.5 What is rehabilitation?

The World Health Organization (WHO) defines 'rehabilitation' as:

> ***'… a process aimed at enabling [people who experience disabilities] to reach and maintain their optimal physical, [spiritual, occupational,] sensory, intellectual, psychological and social functional levels. Rehabilitation provides [people who experience disabilities] with the tools they need to attain independence and self-determination.'***[2]

Rehabilitation is much more than re-learning to do something. It also encompasses processes, skills and strategies aimed at supporting individuals to develop skills for the first time. Strategies and interventions that assist individuals to acquire new skills and build on their current skills necessary to participate in all domains of their life are also vital components of rehabilitation.

1.6 What is recovery?

Given that recovery is a deeply personal experience, it is not possible to provide a simplistic definition. 'Recovery' is a concept that is values-based and focuses on the inherent value and capacity of each individual to engage in a personalised journey of growth in living a meaningful life. The term 'recovery', as informed by people who have a lived experience, infers a process whereby a person constantly utilises their ability to influence the things that stand in the way of living a good life.[3]

Patricia Deegan states that:

> ***'Recovery is not the same thing as being cured. Recovery is a process not an end point or a destination. Recovery is an attitude, a way of approaching the day and facing the challenges. Being in recovery means recognising limitations in order to see the limitless possibilities. Recovery means being in control. Recovery is the urge, the wrestle, and the resurrection.'***

South Australia's Mental Health and Wellbeing Policy 2010–2015 defines the concept of 'recovery' as:

> ***'This approach to recovery emphasises that everyone who experiences mental illness, including those seriously affected by mental illness, can achieve an improved level of wellbeing and a renewed sense of identity, purpose and meaning in life in the presence or absence of symptoms of illness.'***[4]

1.7 Recovery, rehabilitation and recovery-oriented rehabilitation

Over recent years, considerable confusion has emerged regarding the distinction between recovery and rehabilitation. The difference between these two concepts is articulated by Patricia Deegan:

> ***'Rehabilitation refers to the services and technologies that are made available to [people who experience disabilities] so they may learn to adapt to their world. Recovery refers to the lived or real life experiences of persons as they accept and overcome the challenge of the disability.'***[5]

Recovery, then, underpins the way rehabilitation services are developed and delivered and provides a philosophical approach to service delivery.

2 Context

2.1 Key messages

- South Australia's mental health system is undergoing significant recovery-oriented reform.
- The Stepping Up report, which has been a pivotal platform for South Australia's current reform agenda, is a starting point; however, it does not describe all rehabilitation services available to consumers of mental health services in South Australia.
- The NGO sector has grown substantially and is a key provider of mental health services in South Australia.
- Publicly funded government mental health services are reforming their systems and services to better meet the needs of consumers. It is vital that recovery-oriented rehabilitation services also continue to be available and grow in the publicly funded government sector. Models of care and guidelines are important in implementing this change.

2.2 How rehabilitation and recovery are framed in National and South Australian policy

Change in the delivery of mental health care has escalated over the last four decades. Reform agendas have widely documented that a recovery philosophy should be embedded within the provision of all services. A recovery momentum began in the 1980s; however, it has only been within the past decade that the concept of recovery has become embedded in policy and operations guidelines.[6] Historically, 'rehabilitation' services for people who experience mental illnesses have been limited.

2.3 National policy

At a national level, the reform of mental health services has been guided by a number of national directives, including:

2.3.1 The National Action Plan on Mental Health 2006–2011

The National Action Plan on Mental Health 2006–2011 was released in July 2006 by the Council of Australian Governments (COAG). It emphasises coordination and collaboration between government, private and non-government providers to deliver a more seamless and connected care system.

2.3.2 The National Mental Health Policy 2008

The National Mental Health Policy 2008 provides a strategic vision for further whole-of-government mental health reform in Australia. The vision of the National Mental Health Policy 2008 is for a mental health system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in society.

2.3.3 The Fourth National Mental Health Plan 2009–2014

The Fourth National Mental Health Plan 2009–2014 was released in 2009. It builds on the COAG National Action Plan on Mental Health, National Mental Health Policy and the Mental Health Statement of Rights and Responsibilities, and sets an agenda for collaborative government action in mental health. It offers a framework to develop systems of care that are able to intervene early and provide integrated services across health and social domains. It provides guidance to governments in considering future funding priorities for mental health.

2.3.4 The National Standards for Mental Health Services 2010

The National Standards for Mental Health Services 2010[7] have been developed to be applied across a broad range of mental health services. This includes bed-based and community mental health services, those in the clinical and non-government sectors, the private sector, and primary care and general practice. The standards have recently been reviewed and incorporate a recovery standard for the first time.

2.4 South Australian policy

2.4.1 Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007–2012

Stepping Up: A Social Inclusion Action Plan for Mental Health Reform[8] set the vision for mental health services in South Australia to provide a service that is people-centred and recovery-oriented, so as to realise the hopes and aspirations that consumers and their families shared with the Board.

The stepped system of care

The Stepping Up Report described a detailed five-year action plan to reform the mental health system in South Australia to provide better, more responsive services and an integrated system of care.[8]

This has included an acknowledgment that consumers need to have access to additional rehabilitation-oriented services. The report recommended the implementation of a 'stepped system of care', in which the mental health service system is arranged as a tiered care system consisting of support across the community, supported accommodation, community rehabilitation, intermediate care, acute care and secure care. Consumers will be able to 'step up' or 'step down' through the system of care and receive the level of care that best meets their needs and facilitates their recovery.[8] The foundation of the stepped system is people being supported, wherever possible, to live in their own homes within the community.

2.4.2 Growth of the non-government organisation sector

SA Health currently funds a number of non-government organisations (NGOs) to provide a range of mental health specific services including day and group programs, individual psychosocial support services, carer support programs, mutual support, self help and employment programs. The NGO sector also provides psychosocial rehabilitation and support services as part of housing and accommodation support programs. More mental health services are planned and are in implementation phases and many include service provision through partnership with the NGO sector.

2.4.3 South Australia's Mental Health and Wellbeing Policy 2010–2015

South Australia's Mental Health and Wellbeing Policy 2010–2011[77] builds on the strategic reforms and developments outlined in *Stepping Up: A Social Inclusion Plan for Mental Health Reform 2007–2012* and the *Review of Community Mental Health Services in South Australia (2008).*The policy[4] has the following objectives:

- promote positive mental health and wellbeing in South Australia and prevent mental ill-health as far as possible
- protect the human rights of people with a mental illness and support people who experience mental ill-health to live fulfilling lives in our community, without stigma or discrimination
- prioritise early intervention and facilitate timely access to a range of high quality, integrated mental health services that are culturally respectful and meet the needs of South Australians regardless of age, disability, cultural background, geographical location or circumstances of life
- promote and implement principles and strategies that support recovery across the mental health care system and the general community.

2.4.4 Mental Health Act 2009

The Mental Health Act 2009[9] was proclaimed on 1 July 2010 and provides a legislative basis for mental health reform in SA. The Act provides SA with a modern legislative framework that explicitly articulates the rights of people with mental illness and facilitates, to the greatest extent possible, their recovery and participation in community life.[9]

2.4.5 The Statewide Aboriginal Mental Health Consultation: Summary Report July 2010

The *Summary Report* describes the documents the perceptions, beliefs, insights and concerns of Aboriginal people in South Australia about mental health and wellbeing issues. It was produced after consultation with Aboriginal people. It has resulted in thirteen recommendations which aim to improve mental health and well being for Aboriginal South Australians and has seven core elements which should be applied to all services.

2.5 Models of care

A number of Models of Care have been written or revised in the public mental health system in order to support the reform and promote change that is in line with the recommendations arising from national and state policies. Models of care specific to facility based or program based care have been developed as part of the reform process. Two models of care which provide overarching frameworks for mental health services are the Adult Model of Care and Country Model of Care (more detail on the Country Model of Care can be found in 7.2).

2.5.1 Adult metropolitan model of care

The Adult Community Mental Health Services Model of Care provides the over-arching framework for the delivery of adult community mental health services, the consumer pathway, and operational practices and procedures for how services will be delivered.

The model outlines how Community Mental Health Centres (CMHCs) will provide a wide range of integrated services to meet consumers' needs at various stages of their journey, including: acute, early intensive programs; rehabilitation and recovery; specialised state-wide services (such as peri-natal disorders, eating disorders, forensic mental health service links); living and psychosocial interventions; and employment options. CMHCs will provide a key link to all other aspects of mental health care to ensure that consumers are able to access the right service at the right time.[10]

The model outlines **'any door is the right door'** as a principle enabling consumers and carers to access services at any point in the continuum of care.[6]

3 Social inclusion and the social determinants of health

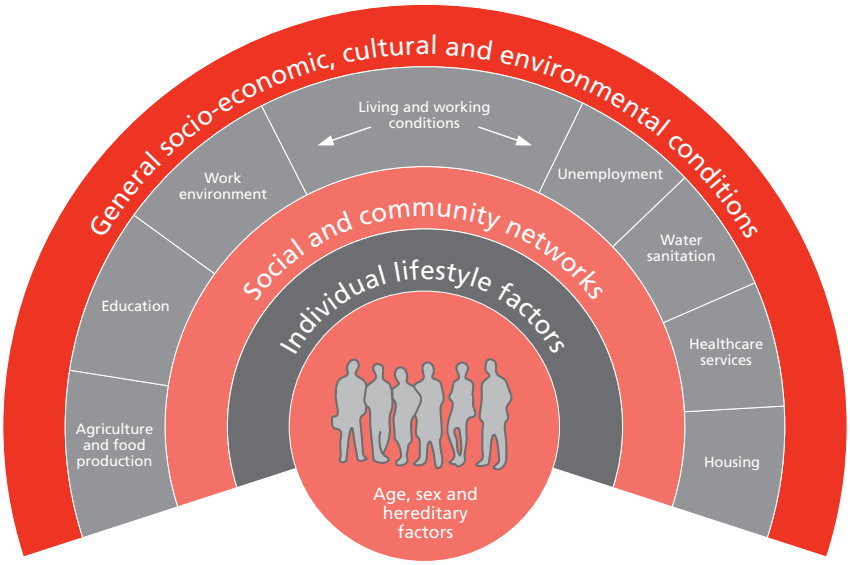
The South Australian Social Inclusion Board identifies that:

> *'… being socially included means that people have the resources (skills and assets, including good health), opportunities and capabilities they need to: Learn – participate in education and training; Work – participate in employment, unpaid or voluntary work including family and carer responsibilities; Engage – connect with people, use local services and participate in local, cultural, civic and recreational activities; and have a voice – influence decisions that affect them.'*[10]

Mental health is shaped by our experiences of everyday life and the social conditions in which people grow, live, love, play, work and age. The social determinants of mental health and wellbeing include general social, cultural and economic environmental conditions; community networks (including support from family and friends); living and work conditions; distribution of money, power and resources; social, individual lifestyle factors; hereditary factors; age; and sex. To be mentally healthy, social determinants of health need to be met, such as security of income; a safe and secure home; community participation and citizenship; and participation in meaningful life roles.

The social determinants of health are depicted in the diagram below, which depicts the layers and interconnectedness of the various sociological, environmental and health-related factors that influence our health and perceptions of wellbeing.[11]

Figure 1: Social determinants of health



Source: Dahlgren and Whitehead's Social Determinants of Health Rainbow, Dahlgren and Whitehead (1991), in Leeds NHS Primary Care Trust, n. d., cited in South Australian Council of Social Service, 2008. Refer to the South Australian Council of Social Service for additional information.

In contrast, people who experience disadvantages such as poverty; unemployment; family breakdown; violence; abuse; poor education; income or housing insecurity; or addiction are more vulnerable to mental ill-health. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.[11]

3.1 Principles for social inclusion

With the endorsement of the Australian Social Inclusion Board, the Australian Government has adopted aspirations and approaches to achieve social inclusion: These are outlined below:[12]

Principles for Social Inclusion

- Aspirations.
- Reducing disadvantage – making sure people in need benefit from access to good health, education and other services.
- Increasing social, civic and economic participation – helping everyone get the skills and support they need so they can work and connect with the community, even during hard times.
- A greater voice, combined with greater responsibility – governments and other organisations giving people a say in what services they need and how they work, and people taking responsibility to make the best use of the opportunities available.

Approaches

- Building on individual and community strengths – making the most of people's strengths, including the strengths of Aboriginal and Torres Strait Islander peoples and people from other cultures.
- Building partnerships with key stakeholders – governments, organisations and communities working together to get the best results for people in need.
- Developing tailored services – services working together in new and flexible ways to meet each person's different needs.
- Giving a high priority to early intervention and prevention – heading off problems by understanding the root causes and intervening early.
- Building joined-up services and whole-of-government(s) solutions – getting different parts and different levels of government to work together in new and flexible ways to get better outcomes and services for people in need.
- Using evidence and integrated data to inform policy – finding out what programs and services work well and understanding why, so you can share good ideas, keep making improvements and put your effort into the things that work.
- Using locational approaches – working in places where there is a lot of disadvantage, to get to people most in need and to understand how different problems are connected.
- Planning for sustainability – doing things that will help people and communities deal better with problems in the future, as well as solving the problems they face now.

3.2 Developing tailored services to support social inclusion

In order to meet the needs of everyone accessing mental health services, it must be recognised that it is often necessary for services to offer programs that support people's social integration in different ways. For example, programs offered by mental health rehabilitation and day programs tend to operate at three levels of integration:

- **Level 1 –** Programs that are provided in a segregated building, solely for people with mental health problems.
- **Level 2 –** Programs that are only for people who experience a mental illness, but they meet in a building that is also used by the general public.
- **Level 3 –** Services support people to pursue their own interests, using services and facilities that everyone uses.

Services may combine the above levels within their program development. The aim is to support people to work towards level 3. As a result, many people will never need to access services provided at levels 1 and 2. It is vital that systems and processes are in place to ensure social inclusion is promoted and not hindered.

For more information and a variety of resources, visit Social Inclusion Board of Australia - www.socialinclusion.gov.au or Social Inclusion Board of South Australia- www.socialinclusion.sa.gov.au/

"...being valued, involvement, helping others. We are all interdependent." *Consumer*

4 Recovery

4.1 Key messages

- Recovery is personal, individual and unique.
- People can and do recover from mental illness.
- 'Recovery' and 'cure' do not mean the same thing. People can and do live well with the presence of symptoms of mental illness.
- Recovery is supported by collaborative partnerships in which key partners develop facilitative relationships to meet the individual consumer's needs.
- Health workers must embrace the potential for recovery in their approach to practice.
- There is no time frame set for an individual's recovery journey. Everyone's recovery journey is unique.
- Recovery is not an intervention and professionals cannot 'do' recovery 'to' people.

Recovery is a uniquely personal process and is directed and owned by the individual. A recovery orientation is the philosophical framework within which services should embed their models and tools, including rehabilitation tools in mental health service delivery, in partnership with consumers to facilitate positive consumer outcomes.[13] This document will specifically focus on the principles of how to provide recovery-oriented rehabilitation.

4.2 An individual's recovery

A definition of 'individual recovery' provided in the *National Mental Health Policy 2008* is:

> ***'A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of mental illness. The process of recovery must be supported by individually identified essential services and resources.***

Research has identified that consumers commonly identify the following to be key themes for their recovery:

- Finding hope.
- Feeling safe, secure and valued.
- Re-defining identity.
- Developing, strengthening and renewing relationships.
- Finding meaning in life.
- Having choices.

Patricia E Deegan describes the personal experience of recovery as:

> ***'…not the same thing as being cured. Recovery is a process not an endpoint or a destination. Recovery is an attitude, a way of approaching the day and facing the challenges. Being in recovery means recognising limitations in order to see the limitless possibilities. Recovery means being in control…to recover, psychiatrically disabled persons must be willing to try and try again.'***[14]

4.3 Recovery and cure

The concept of 'recovery' is often confused with the concept of 'cure'. **Recovery and cure are not necessarily the same things.** People with mental illness can experience a complete remission of symptoms and research confirms that people seriously affected by mental illness can and do recover, no longer need treatment or medication or experience symptoms of illness.[15] More commonly, people experience recovery as living well in the presence or absence of symptoms. Life with a mental illness does not necessarily mean lifelong deterioration, and active treatment and support can play a key role in the recovery process.

The NHS's London position statement on recovery states that almost half of the people who experience a severe mental illness:

> *'… can realistically look forward to no longer experiencing symptoms of illness and less than a quarter are likely to remain severely socially disabled. The empirical evidence comes from studies examining the long term outcomes of people with schizophrenia. A meta-analysis of over 100 studies revealed that more than 20% of participants showed complete social recovery following a psychotic episode (economic and residential independence and low social disruption) and a further 20% showed partial recovery.'*[16]
>
> *When international studies are added, particularly from India and Hong Kong, a similar pattern is seen, with outcomes being particularly favourable in the developing world.*[17]

4.4 The importance of a recovery orientation

A recovery orientation in mental health services systems is an approach in which health care professionals, facilities and services strive to provide services which focus on the potential and capacity of individuals to recover from mental illness, and do so by providing supportive environments, meaningful opportunities and opportunities for consumers to have their needs met and explore possibilities. The right services must be available at the right place for consumers to access them, and at the right time. An individual may benefit from accessing different services at various stages of their recovery. Anthony and Farkas articulate their vision clearly[1]:

> *'Recovery is what people with disabilities do. Treatment, case management, rehabilitation and other services are what helpers do to facilitate recovery.'*

It is this idea of facilitation of recovery that must be central to the role of professionals.[77] In the service delivery context, a recovery approach requires mental health services to actively engage in a flexible partnership with people experiencing mental illness, their families and carers, to encourage and support the person to facilitate their own recovery and experience personal empowerment.[16]

4.4.1 How can mental health workers who work in rehabilitation settings further develop a recovery orientation?

Adopting a recovery approach in practice requires service providers to see the possibilities inherent in each person they work with and strive to offer services that meet their needs and offer opportunities to grow. By using rehabilitative tools and forming interventions based on thorough assessments and developed through active, positive and collaborative relationships with the people they are working with, assertive and creative approaches can be developed and implemented to support individuals' engagement in rehabilitation.

Practitioners need to consider the individual as a whole person and focus on the consumer's entire wellbeing in the context of their social and cultural environment, not merely the absence of disease.

Service providers need to 'walk alongside' consumers in their recovery journey. They can do this by developing a relationship with and getting to know the individual; understanding their values, interests and motivations and creating safe and supportive environments that encourage individuals to explore and master new skills.

4.5 Principles of recovery-oriented practice

The National Standards for Mental Health Services 2010 outline principles of recovery-oriented mental health practice. These recovery principles have been adapted from the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the UK. The purpose of these principles is to ensure that services are being delivered in a way that supports the recovery of mental health consumers.

> *"[I need to be able to choose]…whether to work or not, when well I can work but need flexible hours. To be able to be happy I need control of activities, choice of what work I do, where I live and a peaceful environment."*
>
> *Consumer*

Figure 2: Recovery Principles

1. Uniqueness of the individual

Recovery-oriented mental health practice:

- Recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community.
- Accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life.
- Empowers individuals so they recognise that they are at the centre of the care they receive.

2. Real choices

Recovery-oriented mental health practice:

- Supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored.
- Supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time.
- Ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

3. Attitudes and rights

Recovery-oriented mental health practice:

- Involves listening to, learning from and acting upon communications from the individual.
- Promotes and protects individuals' legal, citizenship and human rights.
- Supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual.
- Instils hope in an individual's future and ability to live a meaningful life.

4. Dignity and respect

Recovery-oriented mental health practice:

- Consists of being courteous, respectful and honest in all interactions.
- Involves sensitivity and respect of each individual, particularly for their values, beliefs and culture.
- Challenges discrimination and stigma wherever it exists within its services or the broader community.

5. Partnership and communication

Recovery-oriented mental health practice:

- Acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them.
- Values the importance of sharing relevant information and the need to communicate early to enable effective engagement.
- Involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

6. Evaluating recovery

Recovery-oriented mental health practice:

- Ensures and enables continuous evaluation of recovery-based practice at several levels.
- Ensures that individuals and their carers can track their own progress.
- Ensures that services demonstrate that they use the individual's experiences of care to inform quality improvement activities.
- Ensures that the mental health system reports on key outcomes that indicate recovery, including (but not limited to) housing, employment, education and social and family relationships, as well as health and wellbeing measures.

4.6 Further developing a recovery orientation

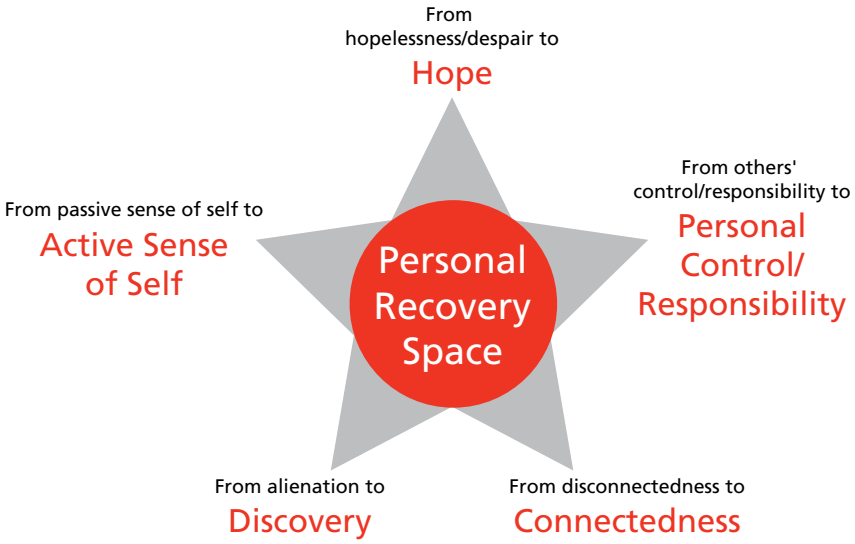
A recovery orientation needs to be integrated into all mental health services' practice. This includes:

- Working together to minimise barriers and maximise potential.
- Supporting consumers to connect with their communities.
- Ensuring services are consumer-driven.
- Enabling access to community resources such as housing, education, work and friendships.

The following diagram outlines examples of the beliefs mental health services workers must demonstrate in order to work from a recovery orientation: it builds on work by Glover (2006) and CNAHS (2010). By working according to the beliefs listed below, services and key partners aim to support consumers to move from a space of:

- Hopelessness/despair to a space of hope.
- A passive sense of self to having an active sense of self.
- Feeling/being alienated to a space of discovery.
- Disconnectedness to connectedness.
- Others having control/responsibility to having personal control/responsibility.

Figure 3: Principles of recovery



Source: This diagram builds on work by Glover 2006 and CNAHS 2010

The following are beliefs that must be demonstrated in practice, to support an individual's recovery space:

Hope

- Recovery is a reality – consumers have the capacity to live beyond the limitations of a diagnosis.
- People are not defined by their illness. They can 'do' and 'be' in the presence or absence of illness.
- Every individual has dreams and aspirations and the right to explore them.
- At times, it is necessary for all people to reach out to others who can be holders of their hope when they cannot hold hope for themselves.

Active sense of self

- A sense of autonomy is important and promotes a sense of wellbeing.
- Everyone deserves to have a high quality of life. It is important to focus on individual strengths and recognise that wellbeing is more than symptom management – it includes social, occupational, emotional, physical, psychological and spiritual dimensions.
- Workers, carers and families play a role in assisting a consumer to identify and utilise personal qualities to overcome the influence of distress or problems.
- Opportunities to acknowledge individual determination, courage and resilience are extremely important.

Personal control/responsibility

- Consumers are responsible for their life work and journey but from time to time, they may need support.
- Consumers have the capacity to be self-directed and take risks and service providers need to create opportunities which allow this to occur.
- Consumers may sometimes need assistance to feel and be in control of their own life, and service providers may play a role in creating opportunities and offering supports that assist this.
- Service providers must 'do with' consumers, not 'do to' or 'do for' them.

Discovery

- Consumers can learn, grow and overcome negative experiences while benefiting from positive experiences.
- There are diverse sources of knowledge in relation to illness and social, emotional, spiritual, occupational, mental and physical health from which to draw.
- Carers and families should work in ways which provide individuals with opportunities to understand how to live well in their community of choice.

Connectedness

- Social inclusion, community support and citizenship are fundamental in a consumer's recovery.
- Consumers live, love, work and play in the community and have the same rights, responsibilities, equity and value as all community members.
- Workers can support and encourage individuals to remain connected with significant people in their life.
- Consumers can overcome stigmatising self-doubts.

5 Rehabilitation within the recovery paradigm

5.1 Key messages

- Best practice rehabilitation is recovery-oriented.
- Recovery is the potential and actualisation of person's individual journey.
- Rehabilitation is the process and tools that practitioners utilise and provide to people to assist in their recovery journey.
- Rehabilitation should be available in all settings and begin as soon as possible.
- Rehabilitation practices should always encompass purposeful evidence-based best practice interventions.
- Rehabilitation techniques provide a range of tools that can be used to assist an individual to gain or regain their independence and strive towards their recovery.
- Rehabilitation occurs on a continuum. All workers need to understand rehabilitation but not everyone needs to be an expert in providing all interventions.
- Rehabilitation enables people to connect and become part of their community and be satisfied and successful in the living, working, learning and social environments of their choice[19].
- People with lived experience of mental illness and their carers should be key collaborators in the development, implementation, evaluation and modification of individual and group rehabilitation programs.
- The process of establishing a positive therapeutic relationship is a part of the rehabilitation continuum. It takes effort and time.
- Rehabilitation requires effort and engagement. Although it may not 'just happen' it rewards both consumers and practitioners.
- Rehabilitation will not necessarily lead to consecutive gains for consumers. Setbacks and overcoming setbacks are part of the rehabilitation process. Rehabilitation opportunities should be offered time and time again.
- Rehabilitation services that are shaped by goals of promoting hope, healing and empowerment ensure mental health services foster an underlying attitude that recovery is possible, offer opportunities for consumers to maximise their own experience of recovery, and create a service environment that is flexible, responsive and accessible.
- Rehabilitation is cost effective and reduces requirements for acute interventions.

5.2 Introduction

The *NSW Health Clinical Rehabilitation Framework 2010* states that:

> *'Rehabilitation' refers to a generic orientation, which is applied to all mental health care, a specific skill set and a specialist discipline requiring specific skills.'*[18]

Rehabilitation techniques can be used as a part of a plan to assist an individual to develop skills and abilities consistent with the recovery-oriented vision of independence and enhanced quality of life. Rehabilitation involves working beyond simply providing services to an individual to increase their level of functioning, and ensuring their basic needs are met. Recovery-oriented rehabilitation always holds the consumer at the centre of care and is a graded process that is based on individualised need.

> *"They encourage me to stay motivated and do not give up. Like they say, try, try again…"*
> *Consumer*

Rehabilitation is a dynamic and evolving process. Recovery-oriented rehabilitation offered by service providers and the strategies implemented are based on individualised need and as such, are likely to change frequently. The approach adopted must always be the least restrictive option and be as consumer-driven as possible at every stage of care. Anthony and Farkas are very clear when they state:

> *'Psychiatric rehabilitation promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that significantly impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed and individualised[1].'*

5.3 Assumptions of rehabilitation

Dutton et al outline the following as assumptions of the rehabilitation frame of reference:[19]

- Compensatory strategies and techniques can assist individuals to increase their independence even when symptoms or illness persist.
- A person's level of motivation impacts on the extent to which an individual regains independence (motivation is a key element that service providers can influence).
- A person's environment impacts on their motivation to perform tasks (the environment can have either an enabling or disabling impact on an individual's motivation).
- Rehabilitation involves a learning process. Cognitive ability impacts on rehabilitation.
- Rehabilitation is an active process and requires effort.
- Rehabilitation needs to consider the holistic needs of the individual.
- Establishing a consumer-centred therapeutic relationship and having rapport impacts significantly on the rehabilitation process.

> *"I need willing assistance from people giving me a go and treating me with respect - and normal."*
> *Consumer*

5.4 Principles for the provision of rehabilitation for mental health

There is one rehabilitation principle which transcends all others and that is articulated by Anthony and Farkas as:

> *'…the principle of personhood, simply defined as people with mental illness are people.[1]"*

This principle arches over all other rehabilitation principles. It is fundamentally recovery-oriented and should be held by workers as the centre of all mental health care provision. The following principles incorporate work by Cnaan, who developed 13 principles for psychosocial rehabilitation and work by Anthony and Farkas (2012) who detail ten psychiatric rehabilitation principles.

Principles for recovery-oriented rehabilitation

- Rehabilitation programs encompass a recovery-oriented, strengths-based focus on developing potential, enhancing and strengthening existing skills and learning new skills.[20]
- All rehabilitation programs and interventions are based on the belief that every person has the potential to engage in the process recovery, ie: consolidate strengths, change, learn and grow. It is an empowering process in which power, autonomy, control, and the right of the person to take risks and make choices are enabled in a safe, dignified and supported way. Rehabilitation programs foster rights and responsibilities, encourage active participation, self-determination, build upon meaningful community connections and support people to pursue a meaningful lifestyle of their choice.
- Rehabilitation operates within a goal-oriented approach. People take different lengths of time to achieve their goals; therefore, program involvement must be individually negotiated. Regular review processes are vital in ensuring that service provision remains enabling and not unintentionally disabling.
- Rehabilitation programs consider the environment and the impact this has on mental health and recovery in either a positive or a negative way.[21]
- Rehabilitation programs and interventions are intended to be stepping stones to assist with community integration and recovery and they do not replace existing networks.
- Rehabilitation is holistic and individualised needs are considered using a whole-of-person approach throughout the life span.
- Recovery-oriented rehabilitation practitioners are socially and culturally sensitive. Rehabilitation practitioners may need to partner with culturally appropriate practitioners, for example, traditional healers (for example, Ngangkari) to maximise results of rehabilitation interventions for Aboriginal people.
- Rehabilitation is accessible to everyone regardless of the setting.
- All services provided are evidence-based and/or demonstrate best recovery-oriented practice.
- All services and care are underpinned by a collaborative partnership approach that involves all key partners, and that the person we are working with and their supports are always at the centre of service-planning, implementation, evaluation and modification.
- Best recovery practice indicates that rehabilitation should be commenced at the earliest opportunity and be voluntary.
- People's recovery goals and rehabilitation needs, supports and strategies should be clearly integrated into the care plan, identify accountability, roles and responsibilities, measurable and achievable goals, and a time line for review.
- Rehabilitation requires effort and engagement. Although it may not 'just happen' it rewards both consumers and practitioners. People must be afforded the time, appropriate support, resources and opportunities to ensure that sustainable rehabilitation interventions create the 'just right challenge', thereby enhancing skill development and allowing individuals to drive their own recovery journey.

5.5 Types of rehabilitation

Types of rehabilitation services commonly accessed and available to people with lived experience of mental illness include but are not limited to:

- Psychosocial rehabilitation.
- Vocational and educational rehabilitation.
- Drug and alcohol rehabilitation.
- Physical rehabilitation.
- Clinical rehabilitation.

Components of the recovery-oriented rehabilitation services named above often combine and/or overlap. It should not be assumed that they operate in isolation from each other.

A variety of tools and approaches can assist service providers in providing rehabilitation services. Examples of strategies and tools that support recovery-oriented rehabilitation practice include but are not limited to:

- Positive therapeutic relationships.
- Practitioner's behaviour.
- Recovery-oriented assessment.
- Recovery goals and care planning.
- Individual's motivation.
- Motivation and goal-setting.
- Motivational interviewing.
- Strengths-based recovery-oriented rehabilitation interventions.
- Therapeutic use of environment.

There is a strong link between rehabilitation and positive individual and cost-benefit outcomes. A number of studies demonstrate an average reduction of more than 50% in the cost of care due to decreased hospitalisations.[22] Workers need to have knowledge of rehabilitation strategies and tools in order to be able to actively assist an individual's recovery.

All of these areas are outlined in depth in Appendix B.

5.6 Psychosocial rehabilitation

5.6.1 Defining psychosocial rehabilitation

The most accepted definition of psychosocial rehabilitation was developed by Cnaan et al. (1998), who defined 'psychosocial rehabilitation' as:

> *'… the process of facilitating an individual's exploration to an optimal level of independent functioning in the community … psychosocial rehabilitation encourages people to participate actively with others in the attainment of … [their] … goals.'*[23]

5.6.2 Psychosocial rehabilitation in South Australia

Stepping Up: a Social Inclusion Action Plan for Mental Health Reform 2007–2012 clearly states that:

> *'psychosocial rehabilitation is not the unique preserve of any one sector'*[8].

A partnership approach is required across and within the government and non-government sectors to support a recovery-oriented system. South Australia has had a distinct history of government and non-government relationship that has concentrated on cooperation, collaboration and degree of pragmatism upon which we can build.[8]

It is important that certain psychosocial rehabilitation functions can move seamlessly across and between government and non-government sectors, based on the needs of consumers, carers and communities.

5.6.3 Discussing psychosocial rehabilitation and recovery

Psychosocial rehabilitation is informed by a belief in the potential of every individual to consolidate strengths, change, learn and grow. It focuses on the individual's strengths and abilities, rather than on their illness. Psychosocial rehabilitation providers work in partnership with key people to provide structured, goal-focused, individually tailored services at a level of intensity and duration appropriate to the consumer's needs.

Common elements of psychosocial rehabilitation exemplify recovery approaches to practice and include:[23, 24]

- Supporting people in recovery to self-manage and to build upon their interests, aspirations and strengths to live full and meaningful lives.
- Facilitating skill development and living skills training to improve confidence and competence in community living
- Supporting wellbeing by encouraging healthy lifestyles.
- Supporting independence and personal resilience.
- Participating in the development of relapse prevention and crisis intervention strategies, thereby reducing reliance on and impact of the use of acute and emergency services.
- Encouraging and supporting engagement in community and social activities.
- Assisting people to access and sustain suitable housing and strengthen social relationships to reduce isolation.
- Facilitating increased opportunities to participate in the workforce.
- Providing training and support in relapse prevention, wellness strategies and recovery by lived experience workers.

5.7 Vocational and educational rehabilitation

5.7.1 Defining vocational and educational rehabilitation

'Vocational and educational rehabilitation' is a set of services offered to individuals who would like to attain or re-develop the skills, resources, attitudes and expectations required to undertake a course of study, interview successfully and/or gain employment.

The majority of vocational and educational rehabilitation services in South Australia are not a part of the Mental Health Service system.

> *Systematic reviews show that people with mental illness who have clear strategies for managing work related stressors are more successful in securing and managing employment than people who do not possess these strategies.*[25]

5.7.2 Vocational and educational rehabilitation in South Australia

> *The Stepping Up Report considers cross-sector collaboration essential to the coordination of treatment and vocational planning. To achieve this, the Social Inclusion Board proposes that State and Commonwealth departments work cooperatively with each other and with Non-Government Organisations, across education, employment and training and Mental Health sectors.*[26]

Many people impacted by a mental illness want to work and they are currently significantly under-represented in the workplace.[26] There is evidence that mental health services are integral to successful employment outcomes for mental health consumers.[27]

5.7.3 Discussing vocational and educational rehabilitation

> *Evidence suggests that while 'up to 90% of people with a psychiatric disability want to work,*[28] *there continues to be difficulties for this group in securing and maintaining employment*[29]*. The unemployment rate for this population is estimated at 75–78% across Australia, which is higher than that of any other disability group.*[30]

Employment has significant benefits for people with a psychiatric disability. Studies show that employment improves quality of life; reduces psychiatric symptoms; improves general functioning; reduces rates of relapse; increases self-esteem and social networks; assists with the development of additional meaningful life roles and routines; and assists with breaking the cycle of poverty and dependence.[31]

> *In a review of supported education programs, Baronet & Gerber concluded that these programs were associated with positive improvements in quality of life, educational and occupational status. It follows therefore that a service that integrates supported education with supported employment would enhance long-term employment outcomes for people with a psychiatric disability.*[30]

5.7.4 Evidence-based principles for vocational, educational, training and employment programs

Enabling Mental Health Consumer Employment Outcomes in South Australia, 2008 cites consistent evidence for the following four principles:

- Eligibility based on consumer choice.
- Integration of vocational rehabilitation with mental health care.
- A goal of competitive (open) employment.
- Rapid commencement of job search activities.

These principles for evidence-based employment programs have been developed from literature spanning at least ten years.

> *We have much to gain from including a focus on education and employment for people with a lived experience of mental illness. Comprehensive recovery-oriented rehabilitation approaches that incorporate employment programs report shorter hospitalisation periods and reduced costs compared with standard care.*

5.8 Physical rehabilitation

5.8.1 Defining physical rehabilitation

After a serious injury, illness or surgery, an individual may recover slowly. It may be necessary to regain strength, re-learn skills or find new ways to perform activities. Evidence-based programs are designed to support individuals in enhancing their skills, so they can do all of the things they need to do and thereby undergo rehabilitation.

5.8.2 Discussing physical rehabilitation

When a physical injury has taken place, individuals are more susceptible to mental health problems.[32] People with a mental illness are more likely than those without to have physical conditions, such as back or neck pain/problems, asthma or heart trouble, further compounding the difficulties they face. *The Australian Bureau of Statistics Survey into Australian Social Trends* highlighted that in 2007:

> ***'… 59% of people with a mental illness also had a physical condition, compared with 48% of those without any mental disorder. After adjusting for age differences in the populations with and without mental illness, the gap between the rates of those with physical conditions further widened.'***[32]

This highlights the importance of ensuring that holistic approaches to recovery-oriented rehabilitation are undertaken and that effective links with primary health care services are made and maintained.

5.9 Drug and alcohol rehabilitation

5.9.1 Defining 'drug and alcohol rehabilitation'

When an individual persists in use of alcohol or other drugs despite problems related to their use, substance dependence may be diagnosed. Compulsive and repetitive use may result in tolerance of the effect of the drug and withdrawal symptoms when use is reduced or stopped. This, along with substance abuse, is considered a substance use disorder.

Drug and alcohol interventions include prevention, early and brief intervention treatment, extended care, residential rehabilitation and withdrawal services.[33]

'Residential rehabilitation' is a term used to describe 24-hour, staffed residential treatment programs that offer drug and alcohol interventions in a structured drug/alcohol-free residential setting.

5.9.2 Principles

> ***Recovering from drug dependence can be a long-term process in which individuals need support and empowerment to achieve independence, a healthy self-esteem and a meaningful life in the community. Successful support for longer-term recovery after treatment requires strategies that are focused on the whole individual and look across the lifespan.***[36]

Harm minimisation is recognised as fundamental to the success of the *National Drug Strategy* and the *South Australian Drug Strategy*. This includes strategies such as:

- demand-reduction strategies designed to prevent the uptake of harmful drug use and to reduce drug use
- harm-reduction strategies designed to reduce the harms associated with drug use for individuals and communities
- supply-reduction strategies designed to disrupt the production and supply of illicit drugs. (SA Health, 2011, 'Drug and Alcohol Services SA', Government of SA, www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+services/Drug+and+alcohol+services/)

5.10 Clinical rehabilitation

5.10.1 Defining clinical rehabilitation

Clinical rehabilitation (CR) is an essential skill set, and should be a part of everyday work for all mental health clinicians throughout the continuum of recovery-oriented service provision. CR interventions should be an integral part of service-planning and service provision, and whenever appropriate, should commence as soon as a person is in contact with any mental health service.

5.10.2 Discussing clinical rehabilitation

Recovery-oriented CR services are specialised, multidisciplinary, integrated with the mental health service, provided in the setting most appropriate to the person's needs, and are planned and delivered in partnership with the person being worked with, their carers, non-government supports and other agencies. All clinicians who work in mental health must be able to collaborate therapeutically with a person to identify their recovery goals, rehabilitation needs and refer on to specialist rehabilitation providers as necessary.

5.11 Continuum of rehabilitation – in a recovery-oriented service context

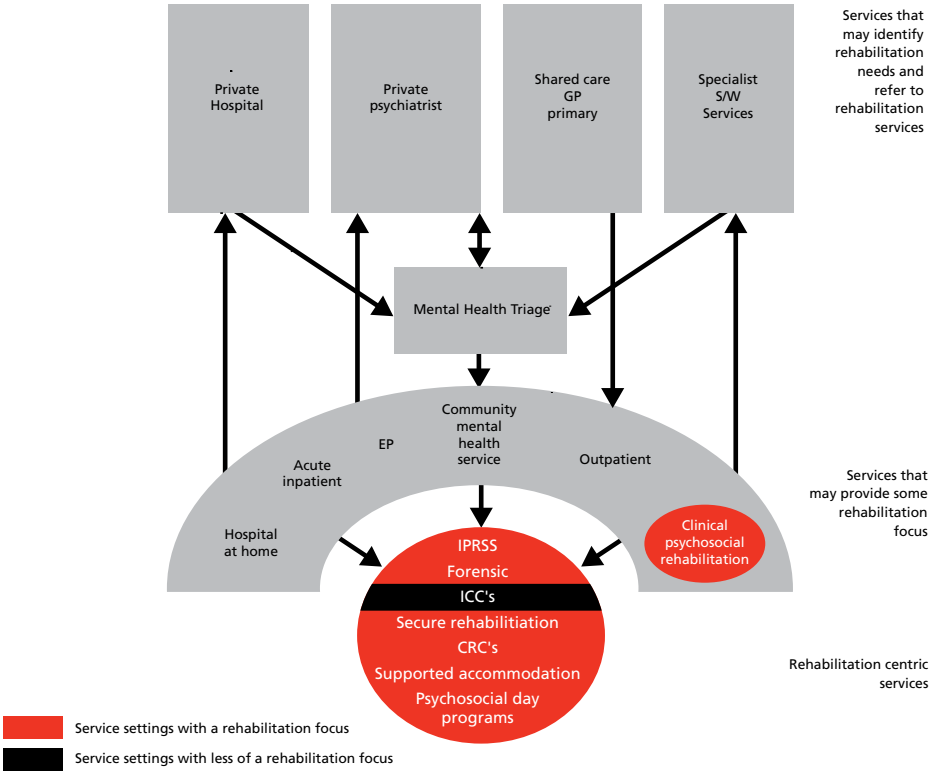
> *"The person must feel ready or get ready, a rehabilitation goal is set; the things the person needs to do and have are identified and the needed skills and resources are developed."*[1]

Rehabilitation is needs-driven and is not confined to one part of a consumer's recovery. Not everyone who experiences an episode of illness will require access to rehabilitation services. However, the need for rehabilitation intervention should be considered when a person is in contact with mental health services. For people who do require access to rehabilitation services, it is vital that the right type of service is available and provided at the right time.

Figure 4 below provides an example of a component of the continuum of rehabilitation services and outlines some adult mental health services offered within metropolitan South Australia. The diagram was designed during a workshop held to assist with the development of this framework. The diagram demonstrates that the mental health service system is complex, and varying services perform different yet equally important functions. Whilst not all recovery focussed mental health services have the core business of rehabilitation, an awareness of consumer driven rehabilitation needs and ease of referral to appropriate services that can meet the rehabilitation needs of the individual is essential. All parts of the service system should be focusing on providing recovery-focused care and treatment, and all parts of this system also have a role to play in providing or preparing for rehabilitation when it is required.[34]

It is important to note that there are other parts of the mental health system which are not represented in the diagram below. A recovery orientation to practice is adopted by all of the services.

Figure 4: An example of the continuum of rehabilitation services in SA



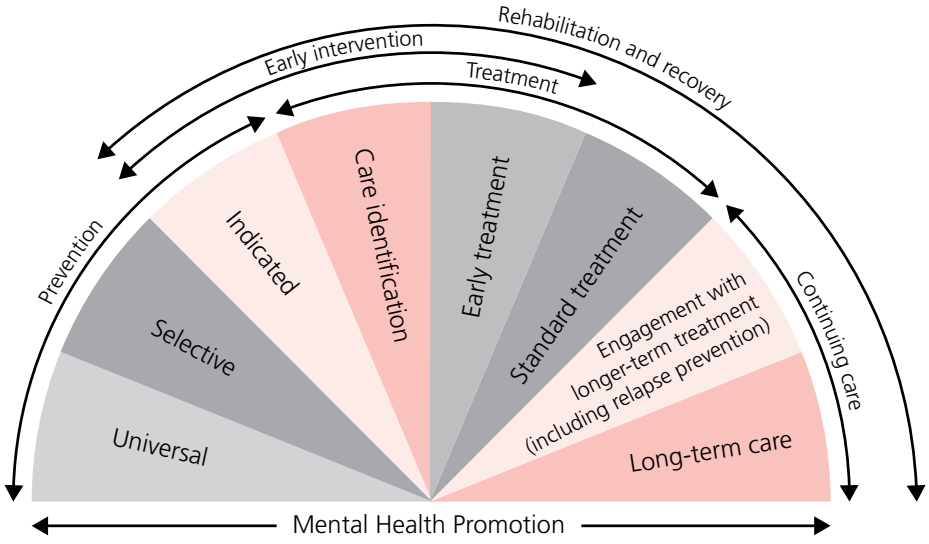
It is also acknowledged that within every service, a continuum of rehabilitation interventions that support recovery need to be available.

5.12 Continuum of rehabilitation – starting it early

The spectrum outlines that assessment of rehabilitation needs begins at the **earliest point of treatment.** A recovery-oriented rehabilitation framework should be available and also involves continuing care, including long-term care. Interventions from promotion to early intervention, treatment, continuing care for people with a mental illness and prevention of the onset of mental illness are key aspects of the framework. A focus on rehabilitation that begins early is illustrated.

This section has been adapted from the following source: Commonwealth Department of Health and Aged Care 2000, Promotion, prevention and early intervention for mental health – a monograph, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra in NSW Community Mental Health Strategy, pp. 4–5.

Figure 5: NSW Spectrum of interventions



Source: NSW Community Mental Health Strategy 2007–2012[22]

The model is based on two assumptions:

(1) There are separate stages in the development of mental health problems and disorders and people progress from having no problems to having non-specific signs and then to diagnosable mental illness/disorder. **A diagnosis does not mean the person will experience a mental illness/disorder forever.**

(2) There are interventions or actions for the different stages which can contribute to the improvement in mental health outcomes and will assist with limiting disabilities.

A crucial feature of recovery-oriented rehabilitation services is to assist people to develop the self-management and resilience necessary to rely more on their own expertise, identify early warning signs and implement coping strategies to prevent episodes of illness and functional decline.

See Appendix D for further information.

5.13 Evidence-based practice and best practice recovery-oriented rehabilitation

Evidence based practice describes the application of treatments and services that have been scientifically confirmed to improve outcomes. There is significant international and local evidence that indicates that recovery-oriented practice results in substantial gains for people living with mental illness in the form of improved symptoms and functioning.[35] There are also significant gaps between the evidence base and what occurs in practice.

Consideration of the importance of recovery-oriented rehabilitation services needs to occur in future workforce-planning for South Australia to ensure that we have an effective rehabilitation sector and people are able to access the right services at the right time.

5.14 Considering individual motivation

In considering individual motivation, Gloria de las Heras et al state that:

> *'One of the greatest challenges for family, stakeholders and an individual is how to help a loved one find interest in the world and explore. Many factors impact on an individual's difficulty in goal setting and motivation including illness processes, interests, values and environmental conditions.'*[36]

The term 'rehabilitation readiness' has been misinterpreted to exclude individuals from receiving services. Readiness is a 'reflection of a consumer's interest in recovery and their self-confidence, not in their capacity to complete a rehabilitation program'.[37]

As service providers, there are a variety of rehabilitation strategies which can be implemented to assist an individual with their motivation. An individual's motivation can often be impacted by the experience of mental illness. Motivation is influenced by patterns of thoughts and feelings that predispose and enable them to participate, choose, experience and interpret behaviour. Motivation pertains to a persons understanding of their recovery ie: their values, what they perceive themselves as being capable of, their interests and what they find meaningful.[38]

5.15 Rehabilitation and disability support

Some people with a lived experience of mental illness, and their families and carers, may require disability support services that maximise their potential to manage everyday life and participate in the community. Such services must be personalised to meet the individual's needs and recovery.

Disability support in mental health services commonly refers to processes, interventions and services that aim to support an individual to maintain their current level of skills and independence (this commonly means workers complete specific tasks for an individual when they are unable to complete these tasks themselves). This differs from rehabilitation, which in its most basic form, aims to enhance and increase skill development, maximise potential to manage everyday life, participate in the community and increase independence (this commonly means working with individuals to support them to develop the skills to increase their independence). Disability support and rehabilitation are both very important services in supporting an individual's quality of life and the need for these services and interventions must be considered based on individual need.

Purposeful and targeted recovery orientated disability support which assists a person to maintain their life in the community is just as important as a rehabilitation intervention which assists an individual to acquire skills.

5.16 Duty of care and dignity of risk

> *It is important to differentiate the risks that must be minimised (harm to self and harm to others) and the risks which people have the right to experience. It is important that we take opportunities to explore possibilities and potentialities for individuals rather that just playing it safe. It is important that service providers are risk aware but focus on the planning in an increasingly collaborative approach that promotes people taking responsibility themselves for ensuring their safety with service supports.*[17]

Duty of care can be defined as

> *'... a duty to take reasonable care and avoid injury to other people or damage to property as a result of action or inaction'.*[39]

Workers have a duty of care to the person they are working with, other staff members in the workplace and in some instances, the public. The law requires workers to take all reasonable care in carrying out their work and ensure that appropriate standards of care are met.

Dignity of risk can be defined as the right of informed individuals to take calculated risks.

Duty of care must be balanced with dignity of risk. It is often necessary to take risks in order to learn and grow and this forms the basis of rehabilitation. Informed decision-making involves a general awareness of the consequences of the decision and the decision being made voluntarily and without coercion. It is important that duty of care is not used to inappropriately limit risk-taking opportunities that promote growth. It is equally important that risk-taking occurs in a supportive way that ensures appropriate supports are still available when required and people are not set up to fail.

5.16.1 Best practice in promoting dignity of risk

Best practice in promoting dignity of risk in a recovery-oriented way:

- Support consumers in opportunities to test, build and enhance their capacities – which may involve creative risk-taking
- have an open attitude to seeing risk as an opportunity for growth and exploring possibilities
- Provide education to consumers, carers and the workforce regarding their rights, and constantly reinforce these rights.
- Involve consumers in their care.
- Recognise consumers as experts in their own care.
- Discuss concepts of rehabilitation and recovery.
- Support consumers to make informed choices in pursuit of their goals.
- Focus on the positives in risks, and the positives that can come out of unsuccessful attempts. Unsuccessful attempts can be used as an opportunity for consumers to redefine and strengthen their goals and develop new strategies for achieving them. This process can assist consumers to develop their resilience.
- Create systems that promote consumer advocacy within organisations and ensure there is consumer presence at all levels of organisational decision making
- Create environments that allow for dignity of risk. Ensure that appropriate accommodation, supports and resources exist so that people living with a mental illness can exercise their right to make choices, take risks, participate and potentially thrive.
- Provide opportunities for risk taking that are supported and have due regard for safety.
- Robust therapeutic relationships provide a key mitigation strategy for risk and a space of safety for learning and exploring together.

> *"I want to have free will. Live by myself and challenge the mental illness label."*
>
> *Consumer*

6 Recovery orientated rehabilitation workforce

6.1 Key Messages

- **All workers who work in mental health need to understand the principles of recovery-oriented rehabilitation.**
- **All clinicians working in mental health have generic clinical skills as well as discipline specific knowledge.**
- **There are different roles within mental health services requiring varying levels of rehabilitation intervention knowledge.**
- **All workers need to be aware of the potential impact their approach to service provision can have.**

6.2 Workers' knowledge and skills

Recovery-orientated rehabilitation services are provided by public, private and non-government mental health organisations. Rehabilitation workers skills, knowledge and professional background will vary. Sharing different knowledge and skills to strengthen services provided to consumers is central to the purpose of the establishment of multidisciplinary teams. At a minimum all workers who work in mental health settings should be able to work collaboratively with a person to identify their rehabilitation needs based on their recovery goals and to identify when these needs may require referral to rehabilitation specialists. The workforce should reflect the cultural diversity of consumers thus improving services' ability to be culturally responsive.

Anthony and Farkas are quite specific about all workers having an understanding and knowledge of rehabilitation.

> *'Regardless of the discipline or background of the practitioner, the source of funding or the setting in which people are working, people who help people with severe mental illnesses improve their functioning and gain valued roles in the community should be aware of the essentials of the psychiatric rehabilitation process, its program models and the principles underlying its practice.*[1]*'*

It is important to outline the specialist skills and knowledge required by a clinician to provide effective and evidence-based clinical recovery-oriented rehabilitation interventions and services. It is also important to differentiate between generic clinical knowledge and specialist rehabilitation knowledge.

6.3 Generic clinical knowledge

Examples of the generic clinical knowledge all clinical staff working in mental health should have include:

- Person first practice and consumer centred care.
- Medical diagnosis systems, psychiatric diagnosis and medical treatment.
- Assessment and outcome measurement methods and practices, including mental health status, risk and consumer-focused assessment and outcome measurement.
- Mental health legislation, policies and procedures.
- Understanding of a recovery orientation to rehabilitation practice.
- Health-related models, including medical, health promotion, wellness and the recovery philosophy.
- Clinical reasoning processes.
- Historical and social contexts of mental health, mental illness and its treatments.
- Ethical and legal issues relating to practice, evaluation and research.
- Knowledge of resources and psycho-education.
- Awareness of the service system, community services and resources and ways of accessing these to ensure consumers' needs are met.
- Acknowledgment and awareness of the different cultures, values and beliefs, and knowledge of how to provide a service in partnership with them.[40]
- Knowledge and ability to work with all partners, particularly the consumer and their carers and supports, to ensure the consumer is provided with the best quality care.
- Knowledge of how to be culturally responsive in service delivery.
- Flexible service delivery.

- Completion of care plans, and standardised suite of assessment tools, such as NOCC, mental state examination, risk assessment, etc.
- Ability to assess needs and set goals collaboratively with consumers and their supports.

6.4 Discipline specific clinical knowledge

Discipline specific clinical knowledge is also expected of clinical staff working in Mental Health. The following is an extract from the *Scope of Clinical Practice in Integrated Community Mental Health Teams (Dec 2011)*. It lists key areas of expertise for each discipline group and acknowledges that these are not exclusive areas of work and there may be significant overlap:

Figure 5: Extract from scope of clinical practice in integrated community mental health teams.

Nursing

- Undertake holistic biopsychosocial assessment.
- Monitor consumer's physical health throughout their care episode.
- Perform physical treatments, interventions and investigations.
- Promote safe effective use of medication by consumer education, encouraging concordance and monitoring responses.
- Manage complex psychopharmacological regimes including metabolic assessment.
- Manage consumers with high and complex physical co-morbidities in partnership with general practitioners and other service providers.
- Promote and support consumers to make healthy lifestyle choices and changes.
- Educate consumers and their carers about their illnesses and treatment.

Medical

- Mental health emergency assessment and management.
- Diagnostic assessment and case formulation.
- Treatment planning including risk management, integration of other health assessments in complex care coordination.
- Education and consultancy.
- Care Provision including prescribing and managing medications, initiating investigations, providing therapy and support and supporting social function.
- Expert opinion: Clinical, medico-legal opinion, Guardianship Board processes, Mental Health Act and its management.

Occupational Therapy

- Functional assessment (independent living skills, functional cognition, social skills).
- Assessment of motivation, routines, roles, skills and environment (MoHO).
- Assessment of community support needs.
- Sensory processing/Modulation.
- Task analysis.
- Graded skills acquisition interventions.
- Graded group work programs.
- Vocational programs.
- Environmental adaptations.
- Compensatory & adaptive techniques.
- Community partnership projects.
- Use of meaningful activity to enhance health and wellbeing.

Social Work

- Promoting environmental interventions to foster the capacity of consumers to adapt within the community and optimise social functioning.
- Individual and relational counselling such as grief and loss, violence and abuse issues.
- Family assessment and interventions.
- Protection of rights and interventions within the legal system.
- Advocacy – systems and individuals.
- Resource to teams on community services.
- Service and community development to address identified gaps.
- Health promotion.

Clinical Psychology

- Provision of specialised evidence-based therapies for specific disorders in individual and/or group based formats.
- Diagnostic assessment and case formulation.
- Consultation re appropriate psychological therapies and approaches.
- Cognitive assessments.
- Psycho-education.

Like all recovery-oriented rehabilitation practices and components of the framework, clinical rehabilitation acknowledges that the least restrictive approach to treatment should always be implemented.

6.5 Workers' knowledge and skills for recovery-oriented rehabilitation

A person who works in a specific team will not necessarily fit into category 1, 2 or 3 all of the time. The categories are fluid, depending on the circumstances and the rehabilitation-specific knowledge required to support meeting the consumer's needs. While someone may have specialist clinical skills in providing rehabilitation (3) in certain circumstances, they may also be someone who works with a rehabilitation focus (2) and refers to another professional with specific clinical rehabilitation knowledge and skills at times.

The categories described below have been adapted from work completed by Golan et al. (2010).

All service providers should have an understanding of rehabilitation and recovery principles, and understand how they relate to each other.

(1) Everyone who works in mental health services

At a minimum all workers who work in mental health settings should be able to work collaboratively with a person to identify their rehabilitation needs based on their recovery goals and to identify when these needs may require referral to rehabilitation specialists. All workers need to have knowledge of resources available outside of mental health services to assist with working with consumers, for example, traditional healers.

Examples of services in which some staff with this level of knowledge and skills may be found in South Australia are: mental health wards, GP Plus, mental health triage, Integrated Community teams.

(2) Service providers who work with a rehabilitation focus

Service providers at this level are working with a rehabilitation focus. They may be involved in providing components of a rehabilitation program, working collaboratively with rehabilitation clinicians, support workers or consumer specialists. Workers will provide practical rehabilitation interventions in their everyday work that aim to support the individual to regain skills, independence and self-determination. They are likely to have undergone rehabilitation specific training and engage in supervision with a focus on rehabilitation.

Examples of services in which some staff with this level of knowledge and skills might be found in South Australia are IPRSS, day and group programs, Community Rehabilitation Centres, Housing and Accommodation Support Partnership (HASP) Program, Intermediate Care Centres, Integrated Community Teams.

(3) Workers who have specialist clinical skills in providing rehabilitation

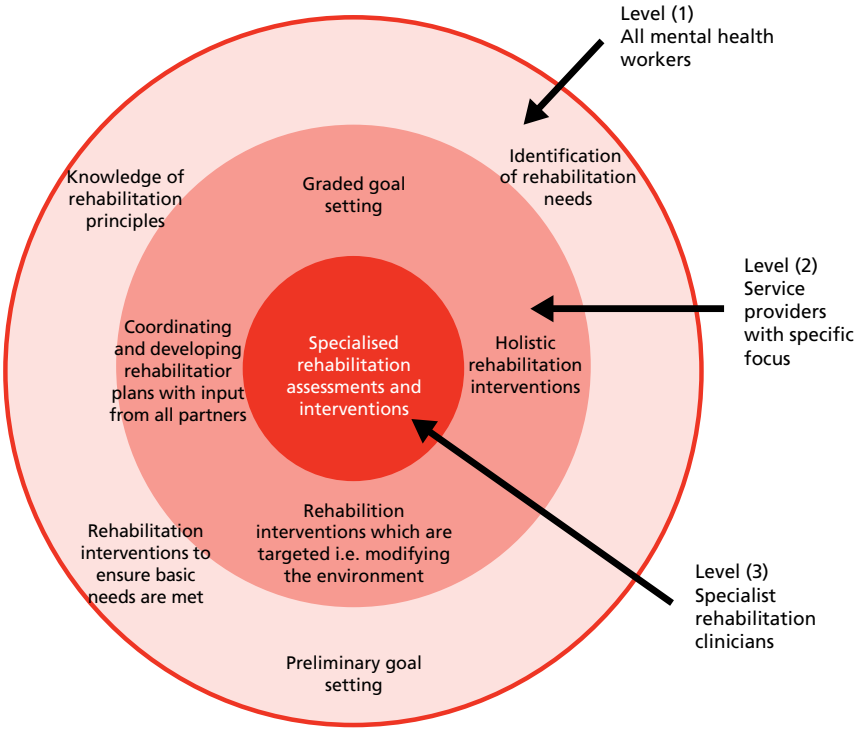
Rehabilitation specialists with clinical training and experience provide individually tailored rehabilitation assessments, interventions and services. They are likely to have undergone post graduate study and training to develop their expertise. They act as rehabilitation consultants to the rest of the service. In considering the holistic needs of individuals, it is often necessary for many experts to contribute to the development of a holistic service plan (many workers with specialist clinical skills may provide specialist input into the development of a rehabilitation plan, with the aim of enhancing rehabilitation processes and the individual's personal recovery).

Referrals to access the right services at the right time are essential for supporting the rehabilitation needs of individuals.

Examples of services in which some staff with this level of knowledge and skills might be found in South Australia are Community Rehabilitation Centres, clinical psychosocial rehabilitation programs, Integrated Community Teams, forensic rehabilitation.

This diagram depicts examples of the specific rehabilitation services and interventions that may be offered by services and individuals working within various categories.

Figure 6: Examples of rehabilitation services and interventions



6.6 Impact of workers' behaviour and approach on service provision

The way in which a mental health worker approaches and develops a therapeutic relationship with a consumer and implements recovery-oriented rehabilitation interventions impacts on the experience and outcomes for that person. Research demonstrates that words only account for 7–10% of how we interpret meaning in face-to-face communication. Interestingly, 35% of how we interpret meaning is related to an individual's tone of voice, and the other 55% is related to body language.[41]

In order for rehabilitation practices to be as effective as possible, it is essential that the core beliefs of recovery are embedded in rehabilitation practices and in each interaction with a consumer, their carers and family. Only when a service partner really embraces recovery in service provision and that their behaviour, body language and tone of voice equates with what is being said will recovery-oriented rehabilitation interventions be provided.

Part of the success of the rehabilitation process is reliant on the therapeutic relationship which develops between the worker and the consumer. The practitioner can facilitate the process by being respectful, empathetic and developing and using active listening skills[1].

> *"I hate it when people speak over me or try to speak at the same time."*
> *Consumer*

7 Meeting everyone's needs

7.1 Key messages

- Different populations have different needs and particular consideration must be given to how best to meet these diverse needs.
- No one service or person can cater to everyone's needs all of the time however mental health services must be culturally inclusive and responsive.
- It is vital that services work together in partnership to meet the needs of consumers, their carers and families.
- Country health services provide services to approximately thirty percent of the population in South Australia.
- Effective communication between consumers and carers needs to take place by a variety of means to meet everyone's needs (face-to-face, written communication, teleconferences, telephone, etc.)

Meeting the rehabilitation needs of all people who experience a mental illness or mental health problem requires special consideration. Not everyone's needs are the same and they cannot be met by the same services. Partnerships are required between various services to effectively meet the broad range of needs experienced by consumers. Target groups for whom improved service access and better service responses are essential include, but are not limited to, young people; adolescents; older people; people with mental illnesses and co-morbidities; people with mental illness and problems with drug and alcohol misuse; people who access forensic services; and people with a full range of mental disorder, including people who are homeless or at risk of homelessness. Specialist programs need to be developed and should consider how to meet the rehabilitation needs of those whose needs are currently unmet.

7.2 Country mental health

The Strategy for Planning Services in South Australia states that:

> ***'The area covered by country health care services in South Australia is almost one million square kilometres, making up approximately 99.8% of the state, and containing almost one third of South Australia's residents. The challenges of supporting access to safe and high-quality health care are as wide and varied as the landscape itself.'***[42]

The demographics and needs of people living in rural and remote areas differ from those of people living in metropolitan Adelaide, and this needs to be taken into consideration when planning and designing rehabilitation services.

Country residents also experience a higher rate of injury and accidents, and face challenges related to drought and other factors, such as natural disasters and isolation, which can put people under extra pressure and may lead to mental health problems.[42]

7.2.1 Country model of care

The Country model of care is a stepped model of care which places primary care providers at the centre, adequately supported by specialist mental health service providers. Service integration and collaboration, facilitated by clinical and care coordination networks, will be a feature of the model of care.[43]

Specialised in-patient services will only be available in metropolitan tertiary centres with low-use in-patient services available in key regional service hubs (country general hospitals). High-use community-based services will be available across all rural areas.

> *"Before we moved to the city the place we lived in didn't have the resources and personnel, or many structures to service our son."*
> *Carer*

7.2.2 Country mental health consumers in South Australia

Distance, remoteness and isolation impact on service delivery and access to the most appropriate health care services, including rehabilitation services. These factors also impact on recruitment and retention of medical, nursing and allied health staff. South Australia's geographical layout is a barrier to the provision of rehabilitation services for all people who would benefit from them. There is also a lack of suitable public transport options across country South Australia, particularly for those residing in the remotest parts of the state; this also limits people's access to services.

While South Australia has experienced a growing diversity of health services provided in terms of accessibility and availability, there needs to be a common goal of achieving consistent high quality service across all country communities while meeting individual local needs. Access to high quality health care should include mental health rehabilitation services. Technology, particularly videoconferencing, is an example of a way of overcoming inequality and providing services to people close to their home.

7.3 Culturally and linguistically diverse consumers

The Australian community is characterised by its increasing cultural diversity.

'CALD' ('culturally and linguistically diverse') is the current acronym describing people who identify with, or have a social orientation towards, a non-English speaking culture.[44]

The Australian Government aims to ensure that 'all Australians with a mental illness have access to effective and appropriate treatment and community supports to enable them to participate in the community fully'. This right of all Australians includes those from a CALD background who may have different needs to the broader populations.

Australia's CALD-background population includes refugees who have had to overcome huge obstacles to resettlement and who are often recovering from the effects of torture and trauma. They may be experiencing grief, depression, anger and other emotional difficulties.[45] Their ability to recover can be supported through access to culturally appropriate services.

7.4 Aboriginal people

Mental disorders account for 15.5% of the total disease burden for Aboriginal Australians.[63] In 2004–2005, 77% of Aboriginal people reported experiencing significant stress in the preceding 12 months.[63]

Aboriginal Australians are more than twice as likely as other Australians to be hospitalised for mental health disorders. Aboriginal males are 5.8 times and females are 3.1 times more likely to die from mental health disorders than other Australians.[63]

Suicide/self-inflicted injuries are the second leading cause of premature mortality among Aboriginal South Australians, particularly among young people. Aboriginal people are three times more likely than other Australians to commit suicide, and residents of remote areas are twice as likely to suicide as are residents of large cities. In Aboriginal communities, 3.7% of deaths are through suicide, triple the rate of the non-Aboriginal population.[63]

The Aboriginal Health Care Plan 2010–2016 has been developed by SA Health to ensure health care services can cater to the distinct needs of South Australia's diverse Aboriginal population. The heart of this plan is to make good health a focus and a priority.

Fundamental to Aboriginal people is a holistic perspective of mental health which encompasses the social, physical, emotional and cultural wellbeing of not just the individual but the whole community. In order to provide recovery oriented mental health services to Aboriginal people which are culturally responsive, services need to create a positive culture of health and support for human rights as well as supporting people to engage in their personal recovery journey.[110] Researchers discuss the "iceberg" theory, where visible mental illness in Aboriginal people is the tip of the iceberg and that services need to consider the whole of the iceberg – the underlying significant social and health disadvantage.[110]

> ***Social and emotional wellbeing problems are distinct from mental illness, although the two interact and influence each other … Social and emotional wellbeing problems can result from: grief, loss, trauma, abuse, violence, substance misuse, physical health problems, child development problems, gender identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism and social disadvantage.***[46]

The *Close the Gap: National Indigenous Health Equality Targets 2008 report* provides the national framework by which to address the national life expectancy gap of 17 years between Aboriginal and non-Aboriginal people. In South Australia, this need is particularly urgent, as the life expectancy gap currently sits at 26 years. A whole-of-government and -service approach, based on strong partnerships with Aboriginal community-controlled health services and Aboriginal communities re-orienting services and funding, will move towards addressing these inequalities.

Grief, loss and trauma reciprocally contribute to these health inequalities and are a major factor compromising the mental health and social and emotional wellbeing of Aboriginal people. Consideration of mental health issues takes place within this broader context and requires new ways of working which support healing and recovery for individuals, families and communities.[47]

The Statewide Aboriginal Mental Health Consultation: Summary Report July 2010 provides recommendations directly relevant to care, regardless of the type of service being considered. Seven core elements have been identified for this purpose and cover the following:

- Engaging people in care to receive assertive and culturally responsive services at first presentation.
- People remaining in care through choice, advocacy, cultural and family support.
- Acknowledging the mobile nature of Aboriginal people through flexibility of service boundary and care plans that follow the individual.
- Where possible, providing care in the community to reduce anxiety related to institutional care.
- Re-orienting services to understand the centrality and importance of family and community in recovery and access to traditional cultural healing and care.
- Connecting people with family, community, culture and country to promote a sense of self and community value.
- Improving the collaborative partnerships, communication and working relationships between the parties involved, such as the various Health workers.

In SA Aboriginal communities traditional healers are an important resource and support for Aboriginal people. Traditional healers, in some communities known as Ngangkari, significantly influence and support the positive management of Aboriginal people's emotional, spiritual and physical wellbeing. It is essential that mainstream mental health services partner with traditional healers in order to provide Aboriginal people with holistic and culturally responsive services.[47]

7.5 Young people

The profile of mental health conditions in younger populations is very different from that seen in the dominant adult (18–64 years of age) service system. This difference needs to be accounted for in service-planning and implementation.[8] The needs of children and adolescents differ from each other, and are different from those of adults. This needs to be at the centre of service-planning and implementation for rehabilitation services. Many children accessing mental health services do not have a formal diagnosis of a mental illness; however, the experience of mental health problems impacts on their daily life. It can commonly impact on their thinking processes, emotions, perception, motivation, confidence and problem-solving, which in turn impacts on their social development and independence. This commonly affects the ability of children to meet vital milestones that act as building blocks for their ongoing development. Targeted rehabilitation services are vital in bridging this gap and supporting their quality of life.

Whilst the principles of rehabilitation/habilitation apply throughout the life span, there are some differences between the needs of child and adolescent services and those of adult services, and this needs to be reflected in rehabilitation programs.

Rehabilitation always focuses on what is meaningful and necessary for the person. For children, habits and occupations commonly focus on play, schooling and interacting with family and friends. Rehabilitation for children and adolescents has a stronger focus on habilitation, providing people with opportunities to develop skills for the first time. Rehabilitation for younger people is strongly informed by the developmental model, focusing on supporting the person to build their resilience and on enabling the person's family and supports to be able to assist their loved one to the best of their ability.

Young people who are experiencing, or are in the early stages of, their first episode of psychosis require specialist interventions that include rehabilitation.[48] Early psychosis usually affects young people at a critical development stage and rehabilitation is a core component of the recovery process; it includes a strong emphasis on psychosocial interventions and support for ongoing education, career options, social funding and support for transition to adulthood.

7.6 Older persons

The Stepping Up Report states that:

> ***"The proportion of older people in Australia is increasing, as is life expectancy. Older people have an increased risk of mental health problems – through pre-existing illness, the recent onset of illness such as depression, and age specific illness such as dementia. They are also more likely to experience chronic physical health problems.***[8]
>
> ***There are very few older people with conditions such as schizophrenia and bipolar disorder. People with a severe mental illness are less likely to survive into old age."***

- It is clear that the profile of mental illness is very different in older people than in the 18–64 year old age group, resulting in a different set of needs. These differences need to be accounted for in service design. The focus of rehabilitation for older persons also varies.

7.7 Forensic mental health

People who access forensic mental health services should have the same opportunities to access rehabilitation services as everyone else. *The National Statement of Principles for Forensic Mental Health (2002)* highlighted that:

> ***'… the relationship between the treatment and rehabilitation culture of forensic mental health services and the custodial culture of correctional agencies is often problematic. Similarly, the police, courts, corrections and forensic mental health have different foci and sets of expectations which can, at times, be difficult to reconcile.'***[49]

Prevention strategies and rehabilitation are vital in supporting the mental health of our community. *South Australia's Mental Health and Wellbeing Policy* highlights the following as priorities in South Australia:

- Support initiatives and programs designed to prevent people who experience mental illness from entering into the prison system.
- Provide specialised services to improve the health and wellbeing of people with a mental illness in the criminal justice system and ensure that there are clear referral pathways to mental health services for offenders in the community.
- Ensure that South Australian forensic mental health services meet the standards articulated in the *National Statement of Principles for Forensic Mental Health (2002).*
- Work to develop a coordinated and consistent operational partnership between forensic mental health services, adult mental health services, the justice system, other government departments and the non-government sector for the delivery of forensic mental health services across South Australia[4].

8 Partnerships

8.1 Key messages

- The consumer is the most important person in the partnership. They and their recovery needs must be considered first.
- Sharing information is essential. The rights of each individual need to be considered when sharing information.
- It is important that the role of each partner involved in care is clearly defined and understood. All partners need to assume responsibility for ensuring smooth coordination of care and everyone needs to be able to contribute equally.
- Carers are an important part of partnerships and need to be considered and included whenever appropriate.
- The process of establishing partnership is as important as the outcome.
- Partnerships should exist to empower consumers, create enabling opportunities for recovery and promote the consumer's dignity of risk.
- The partners are determined based on the needs of the consumer.

Many of Australia's national and state policy documents and plans outline the importance of services developing effective partnerships. *The Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009–2014* outlines a plan to progress the relationship between various sectors and advisory structures to work towards a strategic, coordinated and collaborative approach to mental health across the service system.

South Australia's Mental Health and Wellbeing Policy builds on this and also outlines partnerships and cooperation as one of its main policy directions, stating that:

> ***'Good mental health is everyone's concern and an integrated, whole of community approach is essential to promoting mental health and wellbeing in South Australia. A collective effort from all sectors and services to promote social inclusion and social and economic participation will help to promote positive mental health and encourage a community environment which supports the recovery process.'***[4]

The Stepping Up Report details that in order to meet the needs of people who experience a mental illness, it is often necessary for more than one service/agency/program to be involved, and that many services from portfolios other than mental health already provide a service to people with a mental illness.

The Social Inclusion Board lists a number of priority partnerships, including:

- Education, Employment and Training/Mental Health.
- General Health/Mental Health/Drug and Alcohol Services.
- Child and adolescent psychological wellbeing.
- Housing/Social Care/Aged Care/Mental Health.
- Justice/Mental Health.

It is essential that effective partnerships are formed at all levels of the mental health system. This includes involving representation of key partners (including consumers and carers) in policy-making, planning committees and their involvement in the planning, implementation, evaluation and modification of service delivery.

"Partnership is working together as if we were the same organisation."
Worker

8.1.1 Key factors in building and maintaining effective partnerships

Key factors and values for developing and sustaining effective collaborative working partnerships include:

(1) **Shared values, vision and purpose** – Partners should respect each other and their skills and share a vision of social justice, equality, and enabling and supporting a consumer's recovery journey.

(2) **Focus on relationships** – Open, transparent, honest, consistent and clear communication is important in building and sustaining effective relationships.

(3) **Working together** – Partners work together as a team with consumers, carers and the broader community.

All key partners are involved in care-planning, implementation, evaluation and modification. Whenever possible, and in most instances, the consumer determines who is and who is not involved in their care. Exceptions exist – for example, someone who is on a Community Treatment Order may be required to have certain organisations involved in their care for a period of time.

(4) **Accountability** – Partners are answerable for their behaviour and decisions. Mechanisms are in place to ensure service providers' adherence to applicable standards/expectations.

(5) **Communication and information-sharing** – Partners use a range of processes, structures and documentation to achieve the optimum level of communication and information-sharing, which supports the consumer to achieve the best outcomes. These include:

(a) *Planning*: service-planning occurs collaboratively.

(b) *Reviewing services:* can occur informally during ongoing service delivery.

(c) *Evaluating services:* includes collecting data to guide ongoing service improvement and record outcomes at both an individual and broader program level.

(d) *Partnership agreements or memorandums of understanding*: documents which formally record the relationship between service providers exist.

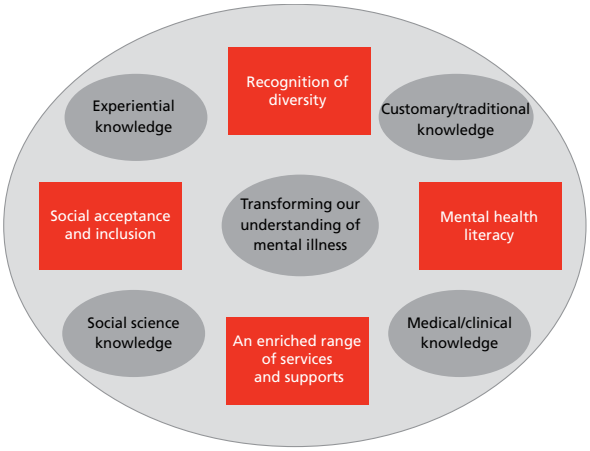
(e) *Knowledge of and capacity to influence service access and pathways of care to ensure right time right place* – any door is the right door.

8.1.2 Establishing partnerships

The process of establishing and maintaining effective partnerships is as important as the outcomes of the partnership. The partnership approach must recognise that consumers, their carers and families have a great deal of expertise regarding consumers' lives. They are directly involved in decision-making and implementation and there is negotiation and agreement between consumers, carers, families and service agencies.

Partners bring different and complementary skill sets to partnerships, with the aim of meeting the needs of the consumer and enabling their recovery journey. To ensure this occurs in a coordinated way, it is important that the role and function of each service provider is clearly articulated, and that their involvement is based on consumer need.

Figure 7: The Knowledge Resource Base[50]



"When I got out of Glenside [NGO worker] got in touch with me and I got the Returning Home [psychosocial support] program and had help with furniture. They also assisted me with help with the move from hostel to hostel. Without them I would be lost. Thanks for not letting me go homeless."

Consumer

Consumers may not necessarily want all of the people in their lives to be involved in their care or change their view of who should be involved over time. Partners should be responsive and flexible in supporting people to have those they wish involved and when. It is vital that all partners have consent to be involved in a consumer's care and the boundaries of the partnership and information-sharing are made clear.

8.1.3 The importance of continuity of care

Continuity of care is vital. The care plan is an important tool in facilitating continuity of care and should identify strategies to enhance strengths and capacities, as well as specific interventions to address or prevent areas of disability and impairment. Holistic needs should be addressed.

8.1.4 Partnerships with consumers

People who experience mental illness (consumers) have a unique understanding of what supports and what hinders mental wellbeing.

Service providers need to recognise that the personal knowledge and expertise of consumers and their carers is equal to, but different from, their own knowledge base. People who experience mental illness must be afforded the information and opportunity to make their interaction with service providers genuine, meaningful, relevant and effective. For example, Aboriginal consumers may request the services of a traditional healer or Ngangkari to be part of their therapeutic process.

Consumers have the right to privacy, dignity and confidentiality in all aspects of care. Whilst it is acknowledged that at times, some people may require involuntary care, this needs to be seen as the last resort and individuals must still be provided with choices; a sense of control must be promoted.

8.1.5 Partnerships with carers and families

O'Hagan in the NZ publication on competencies for recovery workers suggests that:

> *'Recovery happens when people with mental illness take an active role in improving their lives, when communities include people with mental illness and when mental health services can enable people with mental illness and their families to interact with each other.'*[40]

Carers make a significant contribution to the community and to the quality of life of the people for whom they care. The needs of carers should be understood and supported by service providers. This support may involve improving existing support services for consumers, informing people of services that are available (such as carer and consumer consultants, advocates and support groups), developing new supports for carers and providing educational opportunities for families.

> *"I need follow-up after leaving hospital. Checking on medication. I need contact with medical workers."*
> *Carer*

8.1.6 Partnerships with primary health care

Links with primary health care providers are essential in addressing the holistic needs of consumers of mental health services.

Mental health services aim to support the ongoing relationship between the consumer and their GP. It is important for each person's GP to be included in the planning of rehabilitation and for the care plan to outline clearly who will be providing each part of a rehabilitation package. An informed GP can provide support for the consumer, family and other carers during rehabilitation. In order to access many primary health-care providers, a GP referral is required. The Australian Government has recognised that GPs are a vital part of mental health service teams.

The Mental Health Shared Care with General Practice program provides specialist mental health workers to work with and provide support to general practitioners. These workers will provide care (in collaboration with the person's general practitioner) to people who have a complex or chronic mental health disorder, or are at risk of developing one and require early intervention. Mental Health Services may need to partner with Aboriginal community health services in order to facilitate a comprehensive and culturally responsive treatment plan.

8.1.7 Community development and community partnerships

Community involvement, engagement, empowerment, ownership and self-determination are widely acknowledged as key principles that underlie community development approaches to the advancement of mental health and wellbeing. In order to provide integrated services and opportunities for people to participate fully in the community, government and community agencies must work together regardless of traditional organisational boundaries. Partnerships lead to better integrated services.

A community development approach to rehabilitation for mental health includes a move from an isolated treatment approach to one of collaboration, including a commitment from local community organisations to support rehabilitation initiatives.

8.1.8 Partnerships with drug and alcohol services

Access to rehabilitation programs for people with co-morbid mental health and substance use disorders is an important area of need. Access is required to short- and medium-term rehabilitation programs, and more intensive programs for people with severe co-morbid conditions and for whom other treatment options may not be effective or appropriate.

The National Survey of Mental Health and Wellbeing found that of the 183 000 people who misused drugs nearly every day in the 23 months prior to the survey interview, almost two-thirds (63%) had a mental disorder of 12 months' standing. Almost half (49%) of the people who misused drugs other than alcohol nearly every day had a 12 month long substance use disorder, 38% had a 12 month long anxiety disorder and 31% had a 12 month long affective disorder.

8.1.9 Partnerships between mental health services (government, non-government and private)

Services are often provided to consumers from a variety of organisations that may span government, non-government and private sectors. To consumers, it is often not important whether services are provided by government, non-government or private service providers. **What is important is that they have access to the right service at the right time**. This requires services to actively work in partnership and to keep the consumer at the centre of their service provision.

The relationship between service providers should be undertaken with respect and cooperation, following expectations and standards set by each partner.[51] Roles and responsibilities need to be clearly understood, and it needs to be acknowledged that these are likely to overlap. Ensuring the effectiveness of these partnerships requires relevant information to be shared in a timely manner. Current differences in communication systems, documentation systems and technologies between services are examples of barriers that need to be addressed to improve the interface of service delivery.

"Centrelink, Public Trustee, God, enough accommodation, contact numbers, doctors, mental health services, everyday rehabilitation facilities, accessible transport, an understanding of medication and illness in mental health - all help me have control over my life"

Consumer

9 Safety and quality

9.1 Key messages

- The National Standards for Mental Health Services 2010 are applicable to all mental health services throughout Australia.
- Recovery orientation is expected and as National Standard 10.1.
- All services have to perform to standards, and services are measured against these.
- Best practice is about how to continuously improve services. Feedback from partners, particularly consumers and carers, is vital in assisting to improve services.
- Supervision and reflective practice are fundamental concepts that underpin the provision of quality recovery-oriented rehabilitation services. Every worker should have access to regular supervision.
- Quality and safety are everyone's responsibility and need to be integrated into everyday practice.
- Additional research is required to ensure best practice around recovery-oriented rehabilitation remains up to date.
- 'Quality improvement' is defined as 'a continuous process of striving for improved performance, involving problem identification, the testing of solutions and the monitoring of solutions on an ongoing basis.'[5]

A number of overarching safety and quality frameworks exist that are relevant in mental health services, including rehabilitation services. These include *the Australian Safety and Quality Framework for Health Care, the National Safety and Quality Health Service Standards, and the National Health Performance Framework*.

The *Australian Safety and Quality Framework for Health Care*[53] describes a vision for safe and high quality care for all Australians, and sets out the actions needed to achieve this vision. *The Australian Safety and Quality Framework* was endorsed by health ministers as the national safety and quality framework for Australia in 2010.

The framework specifies three core principles for safe and high quality care:

(1) Consumer-centred
- Providing care that is easy for consumers to get when they need it.
- Making sure that health care staff respect and respond to consumers' choices, needs and values.
- Forming partnerships between consumers, their families, carers and health care providers.

(2) Driven by information
- Using up-to-date knowledge and evidence to guide decisions about care.
- Safety and quality data are collected, analysed and fed back for improvement.
- Taking action to improve consumers' experiences.

(3) Organised for safety
- Making safety a central feature of how health care facilities are run, how staff work and how funding is organised.

Additionally, the framework provides 21 steps for action that all people in the health system can take to improve the safety and quality of care provided in health care settings over the next decade. Refer to the *Australian Safety and Quality Framework for Health Care* for additional information.[53]

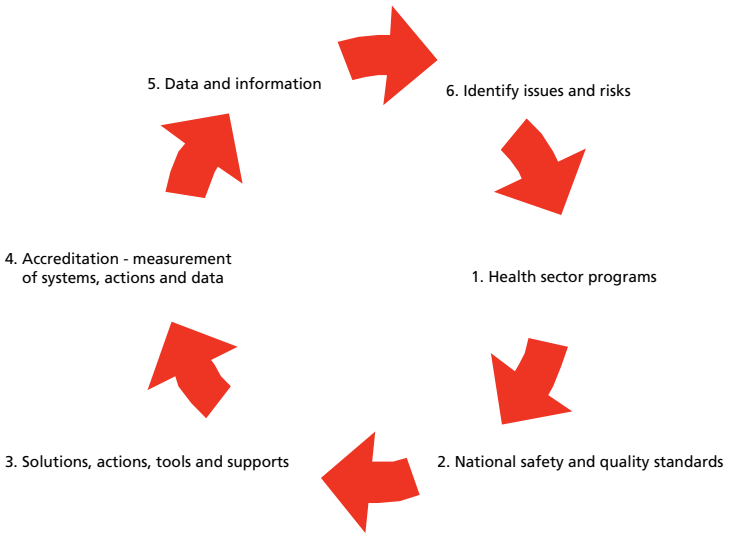
The *National Safety and Quality Health Service Standards* outline ten standards that provide an explicit statement of the expected level of safety and quality of care to be provided to consumers of health service organisations, while providing a means of assessing performance.[54] Specific safety and quality standards relate to the provision of mental health services and relate to the *National Health Performance Framework*.

The *National Health Performance Framework* is linked with the *National Standards for Mental Health Services 2010*. These standards describe care that will be delivered in accordance with the *National Health Performance Framework*, and this is linked with accreditation processes. *National Key Performance Indicators* are also linked to this framework.

9.1.1 Quality improvement

There are many ways of representing quality improvement in health. Quality improvement is something all service providers need to do every day in order to provide safe, efficient and effective practices to consumers, their carers and families. The following diagram is taken from the Australian Commission on Safety and Quality in Health Care [53] and represents activities that services and individuals undertake in order to ensure that best practices are available and implemented.

Figure 8: Best practice activities



Source: Australian Commission on Safety and Quality in Health Care

9.1.2 Health sector programs

All health sector programs, including all mental health sector programs, need to ensure that they are providing effective and efficient evidence-based services that meet the needs of the people with whom they are working.

In the mental health sector, rehabilitation services exist to assist people to build skills and become more independent. These services must be able to clearly articulate the service they provide and consumers, carers and their families should be aware of the service they should expect to receive. The service model, models of care and business rules are vital in clearly articulating the core business of the service, its entry and exit points, and in assisting to ensure the interface between services is seamless.

9.1.3 National safety and quality standards

The National Safety and Quality Health Service (NSQHS) Standards[55] are considered essential to improving the safety and quality of care for patients and clients of health services. They provide a clear statement about the level of care consumers can expect from health services. *The National Safety and Quality Standards* are outcome-oriented with an emphasis on the end result for consumers and carers. The standards are also intended to reflect a strong values base, related to human rights, dignity and empowerment.

Hospitals, Primary Health and Sub-Acute and community services will be required to meet the core actions of the following standards relevant to Rehabilitation and Recovery for mental health across facilities:

1. Governance for Safety and Quality in Health Service Organisations.
2. Partnering with Consumers.
3. Preventing and Controlling Healthcare Associated Infections.
4. Patient Identification and Procedure Matching.
5. Clinical Handover.

Site and divisional management teams will be working to ensure that all core actions are met and managers and staff are encouraged to understand their responsibilities, develop an understanding of the requirements of the National Standards across the health and community sectors in SA.

9.1.4 Developing quality

There are many tools which can be used to develop quality within our mental health services. Activities which are evidence based and used widely in mental health in SA are Clinical Practice Improvement (CPI), Root Cause Analysis, Redesigning Care and Benchmarking. These activities are described and summarised in ***Appendix F.***

9.1.5 Accreditation – measurement of systems

Publicly funded mental health services in South Australia participate in the Australian Council of Health Care Standards Evaluation and Quality Improvement Program (EQuIP).[56] This provides a basis for comprehensive performance management and improvement across all aspects of service provision, and includes accreditation against the *National Standards for Mental Health Services 2010*. The framework includes a self-assessment process and systematic external peer review survey.

Non-government organisations that are funded by SA Health to provide psychosocial rehabilitation support services in South Australia undertake a comprehensive performance management process and accreditation. *The Standards for Psychosocial Rehabilitation Support Services* (PRSS Standards) in South Australia benchmark a recovery-focused service system. Based on a continuous quality improvement (CQI) approach, the standards are an important tool in promoting and monitoring the progress of mental health reform at both the individual service and sector levels.[57]

9.1.6 Data and information

Data and information are essential components of ensuring safe and quality mental health. Use of information in the delivery of health care can ensure that up-to-date knowledge and evidence are used to guide decisions at a service level and at a direct care level. Information is also the basis of reporting and monitoring, which is undertaken at local, state and national levels. Consumer and carer input and feedback are an essential source of information that is also utilised to improve services and care.

Documentation is essential for quality and safe health care. Electronic systems are an important mechanism for recording information. Consideration should be given to ensuring that relevant and appropriate information is shared between service partners. Consideration must also be given to consumer confidentiality.

9.1.7 Identifying issues and risks.

Identifying issues and risks, and putting plans in place to address these, is vital in providing safe and efficient services. All organisations are expected to develop and document risk-management plans to address the specific risks that are identified. Risks may be clinical or organisational. These include physical, environmental, financial, legal, ethical or moral risks and can arise from a variety of sources. They may relate to the organisation, processes, staff or consumers. Risk-management plans consider the likelihood, existing control measures, consequences and level of the risk. Risk-management plans also need to be evaluated.

Identifying issues and risks

- Risk is a normal everyday experience.
- Risk is dynamic, constantly changing in response to altered circumstances.
- Assessment of risk is enhanced by accessing multiple sources of information, but frequently there will be incomplete and possibly inaccurate information.
- Identification of risk leads to risk management.
- Risk-taking is an integral component of good risk management.
- Risk can be managed, but not eliminated.[56]

"I need information, money, food, sex, fresh air, peace and quiet, good sleep, free choice, fruit."
Consumer

9.2 Operationalising quality - the consumers definition of quality

9.2.1 In longer term care

While one of the goals of mental health services is to minimise the amount of time spend in longer term and/or institutional care settings, many consumers will receive longer term care and support.

An international systematic review (over five European countries) completed in 2009[58] on quality of longer-term care identified key components and their effectiveness for consumers. This review classified studies into eight domains of life and found came to the following conclusions that services need to:

- Be located in the community.
- Operate to a flexible regime.
- Be of low density design.
- Maximise resident privacy.
- Offer specific interventions with high efficacy (CBT, family interventions involving psycho education and integrated supported employment) offered by specialist staff.
- Avoid restraint and seclusion wherever possible.
- Train staff in the de-escalation of violence.
- Have adequate staff with clinical skills and regular supervision.
- Involve users in decision making.
- Encourage positive therapeutic relationships between staff and service users.
- Pay attention to service user's physical health through regular screening.
- Have clear lines of clinical governance that ensure adherence to evidence-based guidelines.

9.2.2 In housing

A recent qualitative study[59] relating to housing preferences and choices for people with mental illness have identified key components of quality in housing to include:

- Freedom to come and go and do as they want.
- Own keys, own bathroom, use of a kitchen.
- Having a choice of housing options.
- Sense of community (when in supervised housing).
- Privacy, autonomy, independence, space (when in independent housing).

9.2.3 Operationalising quality – building a shared quality culture

Earlier in this document in Section 7 the key features of successful partnerships have been described. However partnerships provide unique challenges in the quest for quality services. While most partnerships are based on clear relationships articulated through service agreements or memorandum of understandings, a truly effective partnership at the operational level could be defined as – **"working together *as if* we were the same organisation".**

The types of operational practices that service partners may need to consider to ensure quality service provision include:

- Collecting and sharing and acting on meaningful quality data.
- Establishing shared adverse events systems.
- Sharing IT/consumer management systems.
- Including the direct experiences of service partners 'around the quality table' e.g. in a root cause analysis, benchmarking exercise or CQI activity.
- Sharing expertise between service partners in a structured way e.g. shared training, shared professional development activities.
- Building opportunities for workers from each organisation to get to know each other, and build a team spirit across organisations.
- Ensuring evidence-based practice is communicated between service partners.
- Consolidating relationships by developing shared, standardised work practices across organisations.

10 Where to from here…?

- The Core Planning Group for Rehabilitation and Recovery (CPGRR) will be reformed and expanded to widen the membership and will begin to look at the following tasks:
- Develop an implementation plan for *The Framework for recovery-oriented rehabilitation in mental health care 2012* and engage in actively rolling the framework out across SA.
- Identify key priorities to enhance mental health recovery-oriented rehabilitation services in South Australia.
- Develop a strategic plan for improving mental health recovery-oriented rehabilitation service in South Australia.
- Make recommendations to the Statewide Mental Health Executive on strategic directions and forward planning for mental health recovery-oriented rehabilitation services.
- Provide advice to the Statewide Mental Health Executive on workforce development and training needs relating to recovery and rehabilitation.
- Monitor implementation of the strategic plan for the mental health recovery-oriented rehabilitation services.
- Work on articulating the rehabilitation connection between parts of the stepped system of recovery-oriented care.
- Develop clear strategies to communicate the work of the CPGRR to the regions and to partners of mental health services.
- Continue to work on strengthening and enhancing partnership between all partners involved in recovery orientated rehabilitation.
- Contribute to the National conversation occurring about recovery-oriented mental health services.

"The doing is what's important."
Mental health worker

Appendix A: Mental health statistics – some facts

The Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing states that:

> ***'Mental illness affects men, women and children of all ages and cultural backgrounds. In Australia, one in five people will experience a mental health problem or illness each year, and 45% of people will experience a mental health problem or illness at some point during their lifetime.'***[103]

Prevalence rates vary across the life span and are highest in the early adult years, the period during which people are usually establishing families and independent working lives. Earlier surveys of children and adolescents aged 4–17, conducted in 1998, found 14% to have a mental illness.[104]

Housing

South Australia is experiencing increasing housing stress and rental costs. A 2006 state-wide audit of registered community mental health consumers aged between 18 and 64 years highlighted that 30% of people experienced either homelessness or vulnerable housing situations and 10% lived in supported residential facilities.[59, 60] Homelessness can be caused by mental illness and people who are chronically homeless are more likely to have complex needs such as mental health issues.[61]

Physical health

The Australian Bureau of Statistics found that 11.7% of Australia's population aged between 16 and 85 years experienced at least one co-occurring 12 month long mental and physical illness, the figure being 58.5% of all people with a 12 month long mental illness.[62]

People who experience mental illnesses have an increased likelihood of having poor physical health but are less likely to receive effective treatment. Studies performed in Western Australia found that people with a mental illness had a 2.5 times higher mortality rate than the general population, which is equivalent to having a life expectancy in the 50–59 years age range.[62, 22] People with schizophrenia are more likely to have diabetes, and heart disease and obesity are also higher amongst people with mental illness, which in turn impacts on their physical health.[22]

Vulnerable populations and complex needs

There are significant mental health inequalities across the population, as the risk of mental ill-health is higher among those who are poor; homeless; unemployed; poorly educated; victims of violence; migrants and refugees; members of Indigenous populations; children and adolescents; abused women; and neglected elderly persons.[62]

People who reside in the most socioeconomically disadvantaged areas are less likely to access community mental health services as people in areas of least disadvantage access services at 2.4 times the rate of those living in the most disadvantaged areas.[105]

Multicultural population

Over 250 000 first-generation adult Australians from culturally and linguistically diverse backgrounds are estimated to experience some form of mental illness in a 12-month period. In addition, there are many second- and third-generation Australians who experience emotional and psychological distress associated with a history of traumatic life experiences and challenges in addressing cultural identity.[106, 107, 108, 109] It is essential that cultural considerations and individual needs are at the centre of care. It is equally vital that consumers, carers and families from multicultural backgrounds are aware of their rights and make informed decisions. This includes their right to access interpreters. When service providers do not consider culture, this has a significant negative effect on the appropriateness and outcomes of interventions.

Co-occurring substance misuse

People who are diagnosed as having alcohol dependence are more likely to suffer from other mental health problems, and people with mental health problems are at particular risk of experiencing problems relating to alcohol.

The *National Survey of Mental Health and Wellbeing* found that of the 183 000 people who misused drugs nearly every day in the 12 months prior to the survey interview, almost two-thirds (63%) had a 12 month long mental disorder. Almost half (49%) of the people who misused drugs other than alcohol nearly every day had a 23 month long substance use disorder, 38% had a 12 month long anxiety disorder and 31% had a 12 month long affective disorder.[62]

People living in rural and remote areas

In general, the prevalence of mental health conditions in rural and remote Australia has been estimated as equivalent to levels in major cities. However, rural Australians face greater challenges as a result of such conditions, due both to the difficulty of accessing the support needed for mental illness and to the greater visibility attached to mental health in a smaller community. The closure of many of the residential care facilities over the past two decades has had the desirable effect of allowing many people with mental illness to live in the community. Due to a lack of resources, many people with a mental illness struggle to find proper care in the country and are required to seek care in the city, which takes them away from their loved ones. This problem is accentuated if a consumer lives in a rural area which is likely to have fewer health professionals, a much smaller choice of health service providers and scarce community support services.

The Australian Institute of Health and Welfare reports that rates of completed suicide in regional and remote areas are 1.2 to 2.4 times higher than those in major cities.[64] Natural disasters such as drought, cyclones, floods, bushfires and pest infestations also contribute to mental illnesses and have a very direct impact on income and wellbeing for rural Australians.[64]

Appendix B: Examples of tools that can assist rehabilitation in practice

Components of the recovery-oriented rehabilitation services often combine and/or overlap. It should not be assumed that they operate in isolation from each other.

A variety of tools and approaches can assist service providers in providing rehabilitation services. Examples of strategies and tools that support recovery-oriented rehabilitation practice include but are not limited to:

- Positive therapeutic relationships.
- Practitioner's behaviour.
- Recovery-oriented assessment.
- Recovery goals and care planning.
- Individual's motivation.
- Motivation and goal-setting.
- Motivational interviewing.
- Strengths-based recovery-oriented rehabilitation interventions.
- Therapeutic use of environment.

There is a strong link between rehabilitation and positive individual and cost-benefit outcomes. A number of studies demonstrate an average reduction of more than 50% in the cost of care due to decreased hospitalisations.[22] Workers need to have knowledge of rehabilitation strategies and tools in order to be able to actively assist an individual's recovery.

Therapeutic relationships

The therapeutic relationship between the consumer and service provider is an essential ingredient that enables recovery-oriented rehabilitation practice. Positive relationships between therapists and consumers inspire, motivate and lead to increased self-esteem, self-management and involvement in the rehabilitation process.[65] Consumer-centred practice is characterised by collaborative and partnership approaches to practice that encourage and respect a person's autonomy, control and choice and support their right to enact these choices.[66,67] A consumer must be an active participant in the planning, assessment, implementation, evaluation and modification of their recovery goals and the rehabilitation processes that support them. A genuine, effective and active working relationship between consumer and worker that is built on trust, respect, honesty, that looks to possibilities and celebrates the individual's uniqueness service providers are more likely to gain the depth of understanding that truly assists with the collaborative development of the individual's plan. This includes understanding a person's motivations, interests, goals, strengths, barriers, habits, roles, possibilities, current capacity and how well the individual believes they perform tasks within their environment. A safe respectful relationship between the consumer and service provider is vital in nurturing a safe environment in which both parties can exchange feedback, discuss recovery goals and possibilities and in assist the person's self efficacy and self-determination.

Importance of consumer control and impact on rehabilitation outcomes

Studies reveal that improvements in function alone do not lead to quality of life. Focusing on a person's sense of control and creating opportunities in which this can increase in a safe and supported way is a part of a recovery-oriented rehabilitation process. There is an association between perceptions of reduced control and low perceptions of life satisfaction.[68,69,70] Studies also suggest that perceived control is an important indicator of empowerment for people with severe mental illness, and it has been shown to be important for their wellbeing, quality of life and functioning.[71,72,73] A sense of control, in terms of perceived mastery, is an indicator of pervasive recovery, beyond reduced symptomology.[74,75] Thus, perceived control has been shown to be related to health, wellbeing, empowerment and recovery, all of which constitute important objectives in assisting a person who experiences a severe mental illness.[76]

Assessment

It is essential that any plan for mental health rehabilitation is integrated with overall mental health care for individuals. Assessment is a core component of the rehabilitation framework, and it is a joint responsibility of all service providers, consumers, their families and carers. Every person who enters the mental health system is provided with a comprehensive assessment covering all aspects of their general and mental health their recovery goals and rehabilitation needs.[6] Assessments are also incorporated into review processes and focus on a strengths-based

approach, rather than focusing solely on deficits and symptoms. Furthermore, an emphasis on collaborative therapeutic relationships and an individual-centred assessment process ensures acknowledgment of each person's identification of problems that have the most impact on their life, skills, and abilities and may subsequently be incorporated as key items in the management plan. Recovery-oriented effective rehabilitation identifies what a person needs and wants to do and details a plan to address these needs and wants. It is acknowledged that assessments often provide a time-limited view of a person's functioning. Regular review and evaluations are linked with assessment processes.

A joint assessment of need leads to a recovery-oriented planning process and should direct the implementation of services. This information needs to be clearly documented in one care plan. Appropriate evidence-based tools such as self-reporting documents, standardised outcome measures, qualitative tools and assessment of need measures are considered. It is vital to ensure that self-reporting tools are offered for people receiving services and that the information gathered via these tools includes a person's experience and perceptions of care is incorporated into plans of action The data collected should be able to be measured. By ensuring that the person providing this information is unidentifiable, this information should be used to inform evaluation, research and the development of services.

Care-planning

Inter-agency cooperation in the planning and review of recovery-oriented rehabilitation facilitates evidence-based support to be delivered in a way that promotes consumer direction and service coordination. *South Australia's Mental Health and Wellbeing Policy 2010–2015*[77] outlines the need for inter-agency cooperation in ensuring continuity of care for people experiencing a mental illness, and encourages consumer and carer partnership in the planning, implementation and evaluation of care.

A recovery-oriented rehabilitation plan can span the expertise of a number of specialist rehabilitation services and as such, requires an integrated approach to its formulation and review. Development of a collaborative rehabilitation plan driven by recovery goals will lessen duplication and discontinuity of care, and support early intervention and sustained recovery for people with multiple and complex needs.[78]

The mental health care plan has been developed for South Australians in consultation with consumers, carers and clinicians and is a vital recovery driven tool that can help to coordinate and document the process of planning, implementing, evaluating and modifying rehabilitation programs and techniques. The care plan is an interactive flexible document evolves over time through active therapeutic conversations between service provider and the person they are working with. The care plan is owned and held by the consumer to inform all interactions and improve communication across the continuum of care, providing a smooth consumer journey and service experience.[79] There is a commitment to achieve a single information system for South Australian mental health services in order to improve the communication between all services and improve the delivery of care and support to consumers and carers; however, at the present time, the mental health care plan can only be modified by government employees, while the non-government sector utilises a variety of other care plans.

The mental health care plan places at its centre the consumer and carer voice, upholding a person's right to be involved in their own care. **'Nothing about me without me'** is implicit in the thinking behind the care plan, as is the importance of the family and the broader community supports and environment in which a person lives, loves, works and plays. Ultimately, the mental health care plan belongs to the consumer and it seeks to engage all clinicians, workers, consumers and carers in a partnership of care that will assist those experiencing mental health problems and mental illness in a journey towards wellness.[79]

For service providers, the care plan offers a recovery-oriented tool of engagement that develops over time, minimising the duplication of effort and resources, enabling greater interaction between clinicians and consumers.

A collaborative recovery oriented rehabilitation plan may include coordinated approaches by both government and non-government agencies and encompass clinical, psychosocial, vocational, physical and substance addiction aspects, according to need. The role of each agency can be determined by their area of specialty and communicated clearly and uniformly with the person receiving services to promote a coordinated approach. Routine inter-agency communication and review, with active consumer engagement and carer partnership, will assist ongoing development of collaborative recovery-oriented rehabilitation plans.

Motivation and goal-setting as a tool for recovery-oriented rehabilitation practices

Service providers often expect the people they work with will respond to verbal invitations to engage in activities, and that such participation will be helpful, but this does not always occur. Time, patience and a supportive environment free from unrealistic expectations, and is hopeful and awake to possibilities for full and rich and fulfilled lives, are necessary to facilitate recuperation from powerful experiences[80] of ill-health.

Goal-setting is a key evidence-based coping strategy that is incorporated into recovery-oriented rehabilitation practice, and when based on a persons values, desires and skills, it can assist with motivation. Effective goal-setting allows individuals to determine the things that are meaningful to them and clarify the steps to achieve these goals and hence actively participate in their own health care. It should be an empowering process and is widely documented as being an essential element of effective service provision.

Setting goals with an individual requires specific skills and occurs on a continuum. An individual does not need to be able to express their recovery goals and know exactly what they want when asked about their goals to be able to engage in rehabilitation or the goal-setting process. Goal-setting may initially occur in an unstructured way and change into structured, documented goal-setting sessions. Goal-setting with a person may not ever occur or need to occur via structured goal-setting sessions.

A service provider's role can be to support a person to explore what is meaningful in their life, things that may need to change or build towards and identify small steps towards this. When a person finds goal-setting challenging, the effectiveness of the goal-setting process is reliant on the service provider's skills, the therapeutic relationship they develop with a person and the creation of environments to support the person to move from the stages of exploration of new skills to feeling competent about their abilities, to achieving the new skill and successfully incorporating the use of this skill into their life. Assertive yet respectful recovery-oriented rehabilitation approaches may be required that consider duty of care and what is in the best interest of a consumer when illness is impacting on a consumer's engagement with their recovery and rehabilitation.

If a person does not engage with services and does not 'have recovery goals', it does not necessarily mean they are not ready for rehabilitation. It does mean that the style, skills and techniques implemented with the person should be targeted to support the person to safely explore the possibilities for goal setting and learning new skills. The length of time this will take will vary for each person. It is therefore vital that service providers providing recovery-oriented rehabilitation interventions are aware of where the person is at and the indicators that help guide appropriate and supportive rehabilitation skills and interventions for the person at that point in time.

Goals should:

- Be recovery-oriented and based on the needs and wants of the individual.
- Be owned by the person and supported by significant others.
- Be focused on the present, but hopeful and driven by possibilities for the future.
- Be specific, measurable, achievable, realistic and time-framed (SMART).
- Clearly identify stakeholders and their roles in working towards the goal, the tasks they will undertake and by what time they will complete these.
- Focus on action the person can do.
- Be aspirational and capture that the person is more than their experience of illness.
- Be broken down into small steps that set people up to experience success.
- Be a process that supports an individual to experience a continuum of gains as outlined below:[38]
  - A person explores new things and skills in a safe environment.
  - A person develops their sense of competence and their sense of personal control increases. They solidify new ways of doing via exploring new skills, developing these skills and refining old skills.
  - A person achieves new skill development, and has sufficient skills and habits that allow them to pursue something new. The person integrates this skill into their life.[38]

(Adapted from Gloria de las Heras et al. 2007.)

The continuum of skill development outlined above is dynamic. It not only relates to the overall goal, it also refers to the process of working towards and achieving the steps and skills that need to be attained in order for the a person to achieve their goal.

Goal-setting cannot be separated from a person's motivation. Key to any rehabilitation practice is getting to understand a person, their motivation and barriers to their motivation. Considering why a person prioritises goals the way they do, why these goals are meaningful to them and how they are influenced by their values is key to supporting a person's long-term engagement in activities. Research demonstrates that people are more motivated to do the things they are good at, that provide them with a sense of achievement; it is therefore essential that when setting goals, service providers ensure that support, environments and tasks are set up to provide the person they are working with, with a sense of achievement.[80] The acquisition of skills occurs in a graded manner – if tasks are too hard and people experience failure, they are less likely to try again. Research also demonstrates that long-term engagement and gains are heightened when the goals set are meaningful to the individual and are based on what they think is important, rather than what others believe is important. Service-oriented goals, linked to duty of care, are more likely to be embraced by the person if they are clearly linked with them achieving what is important to them and they can assume ownership over the goal.

Motivational interviewing

Motivational interviewing is widely used in mental health settings and can be beneficial for consumers with co-morbidity by increasing treatment motivation, adherence and behaviour change.[81,82] Motivational interviewing is a person-centred approach to supporting changes in behaviour through the exploration and resolution of ambivalence, and is oriented towards collaboration and autonomy.[83] It is directive, non-confrontational, consumer-centred and has stemmed from drug and alcohol services.

Techniques of motivational interviewing that assist with rehabilitation include using open-ended questions that prompt the consumer to think in different ways, providing affirmations, reflective listening and summaries. Motivational interviewing is a client-centred counselling strategy aimed at increasing a person's motivation to change. This strategy assumes equity in the consumer–counsellor relationship and emphasises a consumer's right to define his/her problems and choose his/her own solutions. It is, in this sense, a counselling style based on collaboration rather than confrontation, evocation rather than education and autonomy instead of authority, as opposed to a set of techniques.[81]

Strengths-based interventions

The strengths perspective obligates workers to understand that innate capacities, strengths and potential to flourish of people they are working with. When people are unwell and disempowered it is incumbent on service providers to hold hope for them and recognise that despite being unwell have managed, survived summoned resources and coped. They have taken steps,. We need to recognise and be curious about what they have done, how they have done it, what they have learned from doing it, and what resources (inner and outer) were available in their recovery journey to this point. People are always working on their situations, even if just by deciding to be resigned to them; as helpers, we must tap into that capacity and elucidate it, find and build on its possibilities.[84]

Strengths-based practice has a strong theoretical foundation as an effective helping strategy that builds on a person's successes. Focusing on strengths is a key principle of rehabilitation. There is growing empirical evidence informing outcomes associated with strengths-based approaches.[85] There is ample evidence, documented extensively over 30 years, that people can and do learn how to live with and recover from serious mental illness.[83] If workers focus on strengths, and discuss this with consumers, their self-awareness of their own strengths, abilities, possibilities and self-determination can increase. The *Framework for recovery-oriented rehabilitation in mental health care SA Health 2012* advocates a model that focuses on promoting wellness, as well as appropriate management of symptoms. This includes the need for services to help people to maintain a stable level of wellness, to address prevention and potential relapse, and work with consumers as they build personal strengths to facilitate their recovery.

Therapeutic use of environment

Recovery-oriented, holistic and consumer-centred rehabilitation considers the environmental context in which people undertake the activities they need and want to do. The places in which people live, love, work and play are pivotal and service providers can influence such environments to assist a person's motivation, engagement in tasks and their recovery. Interactions between people and their environment are dynamic, and change within any part affects the other parts.[86] Environments can have an enabling or constraining effect on people being able to do the things that are meaningful and important to them.

In forming recovery goals and rehabilitation plans, it is vital that the environment is considered. Environmental considerations include:

- Cultural (ethical, racial, ceremonial and routine practices, based on ethos and value systems of particular groups).
- Societal (society and practices, including policies, decision-making processes, procedures, accessibility and other organisational practices. This includes funding priorities, employment support, legal components, legislations and political practice).
- Physical (natural and built surroundings that consist of buildings, roads, gardens, vehicles for transportation, technology, weather, access to resources, lighting, space and layout, and other materials).
- Social (social priorities about all elements of the environment, patterns of relationships of people living in an organised community, social groupings based on common interests, values, attitudes and beliefs).[86]

Workforce and professional development

The provision of high quality mental health recovery-oriented rehabilitation services depends (largely) on the quality, skill and commitment of service providers. Service providers are a primary resource to the people they are working with and as such their efficacy, effectiveness and impact is reliant on education and training; support programs; critically reflective practice, research; quality and review mechanisms into improving service provision. The recovery orientation and competence of workers is the responsibility of both the workers and the organisations. Organisations must ensure that the infrastructure and resources are in place to ensure that the workforce continues to grow, develop and provide the best possible services at all times. A commitment to lifelong learning, self reflective practice and ongoing training opportunities is essential in enabling this. Organisational systems and structures are vital to help transfer training and learning into practice. This includes a commitment to discuss recovery-oriented practices within supervision sessions, team discussions, implementation and change management planning, and within strategic-planning initiatives.

The *National Practice Standards for the Mental Health Workforce* is an example of a tool that can be used to promote workforce competence. These are standards that apply to professionals and should be used in conjunction with the *National Standards for Mental Health Services 2010*, and the discipline-specific practice standards, competencies or curricula which apply to specific professions, including social work, nursing, psychiatry, psychology and occupational therapy. The Practice Standards are intended to complement each of the professional groups' discipline-specific practice standards or competencies and address the shared knowledge and skills required when working in a multidisciplinary mental health environment. The Practice Standards should be met by mental health professionals within two years of commencing work in a mental health service.

Supervision and reflective practice

Supervision and consultation are fundamental concepts that underpin the provision of quality recovery oriented rehabilitation services.[86] Every worker is entitled to, and should have access to, supervision. Various models of supervision exist, which have evolved over time, depending on organisational and service delivery context. Methodological, structured and sound research on the effectiveness of models of supervision to inform practice would complement practice-based wisdom and experience in this area. Supervision is consistently reported to be an effective strategy in improving recovery-oriented practice. It is an important strategy to promote quality control, maintain and facilitate the supervisee's competence and capabilities and help supervisees to work more effectively. Effective supervision that is focused on best recovery outcomes consumers has been linked to reducing burnout; promoting quality and preserving a recovery orientation and ensuring best care for consumers; an increase in workers' self-awareness and resilience; increased skills in critical reflection and self-awareness; evidence-based practice skills; promotion of standardised performance across the organisation; increased job satisfaction and self-confidence; improved worker retention; and lifelong learning skills.[87,88,89,90]

Ensuring that supervision is a mandatory part of practice for every worker of the mental health workforce is vital in ensuring services provided are recovery-oriented, appropriate, accessible, flexible, supportive and responsive to consumers, their carers and families. Despite a rising tide of supervision policy and organisational expectation, not everyone has the same access to, training in, uptake of, and understanding of, supervision. The effective provision of supervision requires training, thought and preparation. Different guidelines are used and implemented in various mental health settings. Different professions also have different guidelines and minimum standards. For some professions, these are linked to professional registration and for others, they are not. When applied formally, supervision has benefits in quality and safety of care, together with individual practitioner and organisational benefits.[87] The literature also highlights a growing emphasis on supervision as a space for thinking, reflection and creating possibilities. Reflective practice is an essential element of supervision that promotes professional growth.[91,92,93,94,95,96] Supervision therefore has an important role to play in ensuring that recovery-oriented rehabilitation practice is integrated into all aspects of every individual worker's practice.

The National Standards for Mental Health Services, *The Framework for recovery-oriented rehabilitation in mental health care SA Health 2012* and the *National Practice Standards for the Mental Health Workforce* are examples of tools that should be incorporated into supervision sessions. It is vital that service providers discuss their practice and are accountable for providing recovery-oriented rehabilitation services to consumers, their carers and families.

Appendix C: The stepped system of care

Secure care

Secure rehabilitation provides assessment, treatment and rehabilitation interventions in a flexible, secure environment, by using a 'step up, step down' model providing graduated levels of care for consumer groups with differing needs and levels of recovery.[97]

Secure rehabilitation is a state-wide service that aims to provide consumers with a safe and secure environment that values consumers and holds hope of recovery, whilst providing opportunities to explore issues and regain skills for independent living; and with improved quality of life through a rehabilitation program that progresses the consumer to a less restrictive environment.

Secure rehabilitation is gazetted under the Mental Health Act as an Approved Treatment Centre to provide involuntary care. It is intended to provide consumer-focused assessment, treatment and rehabilitation to people with a mental illness who pose a significant risk of harm to themselves or others, and whose needs cannot be met in a less secure setting. The purpose of the service is to provide rehabilitation aimed at affecting changes in the consumer's quality of life, optimal functioning and community reintegration.[97]

Hospital acute beds

Part of the reconfiguration of mental health services in South Australia has included the transferring of resources from the acute in-patient sector to support new parts of the stepped system of care. Part of the reconfiguration will include the Glenside Hospital redevelopment, which will ensure that Glenside will have modern, state-of-the-art facilities that meet the service needs of people with a mental illness or with a drug and/or alcohol dependency.

Intermediate Care Centres

Intermediate Care Centres (ICCs) offer a step down from hospital care. They are designed to be used in the short term, offering care, treatment and rehabilitation to provide individuals with support to avoid a hospital admission. Intermediate care (IC) is a service approach for people who are unwell but no longer need acute in-patient treatment, or who are at risk of or experiencing an acute mental health episode but do not require an acute in-patient admission.

The differentiating feature of intermediate care from other services within the continuum is the focus on the delivery of care that encompasses intensive, nurse-led clinical treatment and multidisciplinary bio-psychosocial rehabilitation.[98]

The service is provided 24 hours a day, seven days a week, and offers a short-stay residential and psychosocial support program. Facilities are located in metropolitan and rural areas. There will be four 15 bed ICCs in Metropolitan Adelaide – located in the east, west, north and south. Community based intermediate services are now in place in Country SA and hospital based places will be embedded in four general hub hospitals.

Community Rehabilitation Centres

There are three 20-place Community Rehabilitation Centres (CRCs) operating within metropolitan Adelaide:

- Trevor Parry Centre in the south.
- Elpida House in the west.
- Wondakka in the north.

Two 10 place CRCs are being developed in Country South Australia and will be operational in 2013/14. They will be located in Whyalla and Mt Gambier.

CRCs are rehabilitation facilities located in the community, which provide goal-focused rehabilitation to mental health consumers with high and complex needs.[99] Consumers stay at the CRCs for varied amounts of time, usually between three and nine months.

The rehabilitation program provided at CRCs focuses on supporting consumers to:

- Build healthy routines and lifestyles.
- Develop an awareness and acceptance of mental health needs.
- Understand early warning signs to help consumers make useful plans.
- Improve access to services.
- Build practical skills for independent living.

Supported accommodation and housing

Supported accommodation is defined as safe, secure and affordable housing supported by both specialist mental health services and psychosocial support services to enable individuals with a mental illness to recover and live independently in the community. 'Supported accommodation' refers to the continuum of programs providing housing in the community with specialist and psychosocial mental health support, from intensive (up to 24/7) support to flexible, less intensive support, provided under formal agreement between the parties.

The aim of mental health housing and supported accommodation programs in SA is to provide supported accommodation programs that are individualised, holistic, integrated and flexible for people with a mental illness and severe and enduring psychiatric disability who initially require intensive support in order to live in the community.

There are a number of mental health supported-housing and accommodation programs in South Australia and all are in the process of being aligned with the Supported Accommodation Principles, which are detailed below.

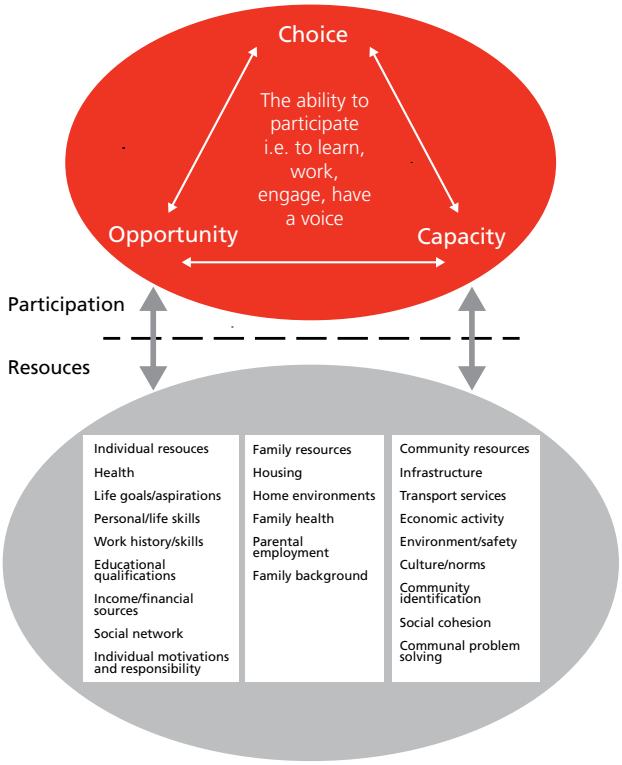
Supported accommodation programs should:

- Be recovery focused.
- Provide housing which is normal, affordable community housing.
- Provide individualised support and accommodation.
- Have clusters no greater than six.
- Have partners performing their core business, that is:
  - mental health services providing mental health care
  - specialist NGOs providing psychosocial rehabilitation and support
  - housing providers providing housing and tenancy management.
- Ensure that formal and informal supports work together to meet a person's needs.
- Go beyond assisting a person to maintain their tenancy and security of tenure and mental health and aim to assist people to connect with their community.
- Have written partnership agreements between service partners.

(Drawn from Rog 2004, Wong 2006, Bostock et al. 2000[100])

Note: The principles outlined above are derived and supported by an evidentiary base and extensive reviews of the international evidence in the literature regarding what are the successful features of supported housing models.[24]

Figure 9: Social inclusion conceptual framework



Appendix D: Spectrum of interventions

'Mental health promotion' is any action taken to maximise mental health among populations and individuals. It aims to protect, support and sustain the emotional and social wellbeing of the population. It is applicable across the entire spectrum of mental health interventions and is focused on the promotion of wellbeing rather than illness prevention or treatment. Mental health promotion fits within the rehabilitation frame of reference.

'Prevention' is defined as 'interventions that occur before the initial onset of a disorder' to prevent the development of a disorder. Prevention focuses on reducing the risk factors for mental disorder and enhancing protective factors. Prevention interventions can be universal, targeted at the general population, selective for population sub-groups or individuals with a higher risk of developing mental disorder, or indicated for those with minimal but detectable signs or symptoms which do not meet diagnostic levels.

'Early intervention' refers to interventions targeting people displaying the early signs and symptoms of a mental health problem or mental disorder and people developing or experiencing a first episode of mental disorder. These interventions occur shortly after a need has arisen, aiming to reduce distress, shorten the episode of care and minimise the level of intervention required. These include indicated prevention interventions.

'Treatment' is made up of early intervention in the form of proactive case identification (in clinical settings or clinical outreach), along with standard treatment for diagnosed disorders. 'Standard treatment' involves the application of effective, evidence-based treatments for individuals with diagnosed disorders.

'Continuing care' comprises interventions for individuals whose disorders continue or recur. The aim is to provide optimal clinical treatment, rehabilitation and support services in order to prevent relapse or the recurrence of symptoms, and to maintain optimal functioning to promote recovery. Ongoing mental health promotion, the reduction of risk factors and the enhancement of protective factors are still relevant at this end of the spectrum.

'Relapse prevention' refers to interventions in response to the early signs of recurring mental disorder for people who have already experienced a mental disorder. It differs from early intervention; the factors which influence the first onset of a disorder may be quite different from those which lead to relapse and recurrence of a disorder, and the standard treatments may also differ. Rehabilitation offers an important set of interventions that can assist with relapse prevention.

Appendix E: National Safety and Quality Standards

Standard 1. Rights and responsibilities

Standard 2. Safety

Standard 3. Consumer and carer participation

Standard 4. Diversity responsiveness

Standard 5. Promotion and prevention

Standard 6. Consumers

Standard 7. Carers

Standard 8. Governance, leadership and management

Standard 9. Integration

Standard 10. Delivery of care

- 10.1 Supporting recovery
- 10.2 Access
- 10.3 Entry
- 10.4 Assessment and review
- 10.5 Treatment and support
- 10.6 Exit and re-entry.

Appendix F: Quality improvement activities

Clinical practice improvement

Clinical practice improvement (CPI) is a method used to improve consumer care through process re-design, and is applied to health care. It provides clinical staff with the tools required to make change and improve the way health care is delivered.

The basic principles of clinical practice improvement are to provide:

- Individuals who work in the system with profound knowledge of the process of care.
- Benefits to units, departments and individuals.
- Improvements to care processes requiring the application of a systemic improvement process that includes teamwork, change-management techniques and creative thinking.
- Health care processes which can be analysed and measured.[101]

Root cause analysis

Root cause analysis (RCA) is a method of investigating adverse incidents. The purpose of an RCA investigation is to identify issues within the system that contributed to, or resulted in, the occurrence of the adverse incident and to provide recommendations for measures to prevent a recurrence of a similar incident.

A root cause analysis team is a team appointed under section 69 of the *Health Care Act 2008* to investigate a Safety Assessment Code (SAC) 1 incident or sentinel event. The designated authority appoints to the team a root cause analysis leader. The team is to consist of no less than three members.

Information provided to an RCA team member, appointed under part 8, section 69 of the *Health Care Act 2008 (SA)*, is used in determining what occurred, why it occurred and how to prevent it from happening again.

- Laws are in place in all Australian states, the Australian Capital Territory and the Commonwealth that protect the confidentiality of some information generated by certain quality improvement activities (including RCA). South Australia's position is governed by the *Health Care Act 2008 (SA) Part 8, section 73 of the Health Care Act 2008 (SA)* deals with protection of information.

Redesigning care

Redesigning care focuses on improving consumer journeys. These journeys could include anything from hospital admission to discharge, to the experience of seeking and then receiving support from a community health site.

Redesigning care uses 'lean thinking' principles as the basis for improving the consumer journey. Lean thinking is about designing processes that focus on value, adding steps in the best sequence and removing unnecessary steps. In health care, this ensures the consumer journey is designed to be as smooth and safe as possible. This approach is used in an array of industries, including health.

Re-designing care uses the 'improvement wheel' methodology, which is a phased approach. Initially, a project is scoped to determine its breadth and to understand the situation. This often includes mapping out the journey or main process. Diagnostics are then undertaken to better understand the problem that needs fixing. Intervention involves testing of different strategies to address the problem. In the next stage, the impact of the intervention is assessed, to determine the level of improvement and whether that is the agreed way forward or could be used in other areas. Finally, strategies are put in place to sustain the improvement. Sustaining is best done by those who are operational and is the biggest and most difficult part of the approach.

Benchmarking

Many definitions of 'benchmarking' have been put forward in the literature. The National Mental Health Plan 2003–2008 adopts the approach taken by Bullivant (1994), who defined benchmarking as:

> ***'…concerned with the systematic process of searching for and implementing a standard of best practice within an individual service or similar groups of services. Benchmarking activities focus on service excellence, customer/client needs, and concerns about changing organisational culture.***

The seminal document that underpins benchmarking within the mental health sector is *Key Performance Indicators for Australian Public Mental Health Services.* This report proposed a set of 13 key performance indicators (KPIs) that could be constructed based on available data collected by all Australian states and territories.[102] These can then be linked with quality improvement cycles and allow services to have regular reports on their performance relative to a similar service. This data can be used to improve practice and service management and delivery.

Appendix G: Acknowledgements

The Framework for recovery-oriented rehabilitation in mental health care 2012 was developed in 2010/11 by the Core Planning Group (CPG) for Rehabilitation and Recovery Services. This group consisted of representatives from metropolitan mental health services, country mental health services, the NGO sector and consumers and carers and was convened by the Mental Health Unit, SA Health. Over the 18 months of development many stakeholders were consulted individually, in groups and through special workshops. Over 150 stakeholders were consulted in the formulation of the final draft and many more through the final draft consultation.

The CPG would like to thank everyone who contributed to the Framework for their time and energy in an environment of competing priorities. The CPG for Rehabilitation and Recovery would particularly like to acknowledge Helen Glover and the mentorship she provided the group in developing this Framework and the partnership extended by NSW Health and the Clinical Rehabilitation Group.

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