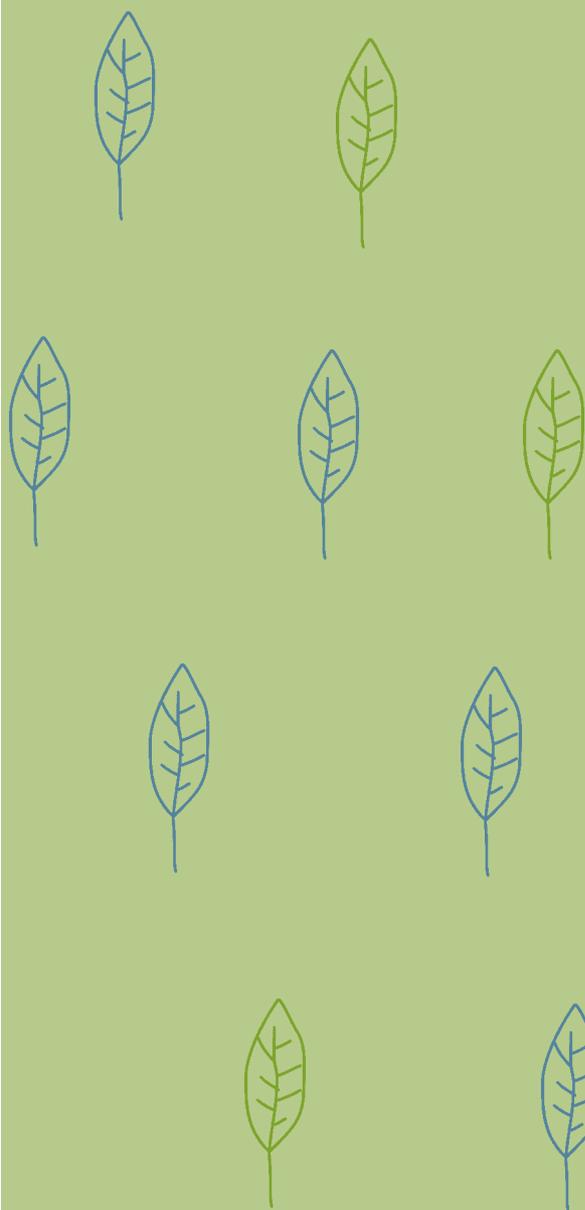


# A Recovery Vision For Rehabilitation Psychiatric Rehabilitation Policy And Strategic Framework



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Office of Mental Health  
Department of Health, Government of Western Australia





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Ensuring the quality of life and maximising the opportunities for people with mental illness is a high priority for the Western Australian government.

People who have a mental illness seek similar opportunities and responsibilities as other members of the community. These people's goals may include their own home in the community, friendships and recreation, relationships with family and community, training and work opportunities.

Mental illness affects as many as one in five Western Australians during their lifetime and, unfortunately, the potential consequences of a severe and persistent mental illness are well recognised. This policy is about maximising the opportunities for people with mental illness and minimising these potential effects on the person, their family and friends and on the wider community.

This policy is based on contemporary rehabilitation philosophies. Central among these philosophies is hope for the future and the concept of the individual recovery journey. It is important that rehabilitation services in Western Australia focus on the recovery journey and improving the quality of life for people with mental illness.

Services to help improve quality of life include case management, appropriate housing, support services (including for family and carers), skill development, education, training and employment services. This policy guides the development of these services and recognises the need to improve integration and partnerships between major rehabilitation service providers.

Following on from this policy, the Office of Mental Health will continue to promote contemporary rehabilitation philosophies and good practice in rehabilitation services throughout Western Australia. A specific initiative resulting from this policy was the inaugural Western Australian psychiatric rehabilitation symposium. This symposium was held in February 2004 and highlighted areas of good practice and provided opportunities for sharing knowledge about effective rehabilitation service provision.

Congratulations and thanks to those involved in the development of this visionary policy and strategic framework. This policy was developed at the same time as, and is complimentary to, the *National Mental Health Plan 2003-2008* endorsed by the Australian Health Ministers.

As Minister for Health, I welcome these developments in the psychiatric rehabilitation field and look forward to the continued development of contemporary mental health services that promote the recovery journey for people with mental illness.

**Jim McGinty MLA**  
Minister for Health

# Acknowledgments

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# Executive Summary



The psychiatric rehabilitation policy and strategic framework represents a significant new direction for the development of psychiatric rehabilitation services in Western Australia. The policy highlights contemporary rehabilitation philosophies, emphasising the concept of the personal recovery journey and the benefits of hope and optimism in supporting people with mental illness to live, work and participate in the community. A range of services and supports are discussed, as are rehabilitation issues for specific populations.

People who have a mental illness seek similar opportunities and responsibilities as other members of the community. These people's goals may include their own home in the community, friendships and recreation, relationships with family and community, training and work opportunities. Overall, the psychiatric rehabilitation program aims to:

- assist people with mental illness to optimise their quality of life including achieving residential, educational, recreational and vocational goals and aspirations; and
- support the recovery journey for people with mental illness and optimise general health and wellbeing.

Contemporary psychiatric rehabilitation approaches recognise the impact that mental illness can have on the person's life and the achievement of their goals. The World Health Organisation (WHO) has adopted a classification framework, which can outline these effects. The effects include:

- impairment – such as delusions and depression;
- activity limitation – such as lack of work adjustment or social skills; and
- participation restriction – such as unemployment, homelessness, discrimination and poverty.

A comprehensive rehabilitation service needs to include an accessible range of services that address the effects of having a mental illness.

The following definition of psychiatric rehabilitation has been adopted in this policy: “the formal principles and active specialised strategies within a comprehensive mental health service system, and external to the system, that supports people with a mental illness to address difficulties in their life roles and participation restriction in society”.

While psychiatric rehabilitation services are the focus of this policy, they need to exist within a continuum of care that includes treatment focussed services. For the purpose of this policy, treatment focussed services are those focussing primarily on impairment. The coordination and integration of these treatment focussed services and rehabilitation focussed services is vital to ensure the best outcome for people with mental illness.

This policy supports the adoption of contemporary rehabilitation philosophies within rehabilitation services and throughout the mental health system to allow people with mental illness to have realistic hope for a positive future, optimism about engaging with



rehabilitation services and a willingness to undertake the recovery journey. To support this, the Office of Mental Health hosted the inaugural Western Australian psychiatric rehabilitation symposium in February 2004. The symposium promoted contemporary rehabilitation philosophies and gave service providers the opportunity to share their knowledge and rehabilitation experiences.

This policy provides core values and service delivery principles to guide service delivery. The following service interventions to assist people with mental illness meet their aspirations are also discussed in detail. Each of these service types can be provided through government or non-government agencies.

### **Targeted Assertive and Intensive Case Management**

This policy supports the targeted provision of intensive or assertive case management for people diagnosed with severe and persistent mental illness who frequently relapse; have complex psychosocial issues; and are unable to participate in the management of their illness or are poorly engaged with mental health services.

The policy also recognises the need for further research to focus on the elements of the various case management models that are effective for different people. The Office of Mental Health will continue to refine its policy position on assertive and intensive case management in light of such further research developments.

### **Comprehensive Rehabilitation Assessment Approach**

A comprehensive rehabilitation assessment approach that supports self-determination and empowerment is essential for effective rehabilitation. Initial and ongoing assessment processes that actively involve the person and, where relevant, the family and the treatment perspective all contribute to a comprehensive approach.

There are considerable advantages to the wide adoption of a standardised approach to rehabilitation assessment that is complementary to other standard assessments. The Office of Mental Health will undertake a comprehensive review of available measures to determine appropriate instruments for adoption throughout the state.

### **A Range of Supported Housing Options**

Stable and appropriate housing is fundamental to successful psychiatric rehabilitation and the recovery journey. This policy endorses establishing a real home in the community as the ultimate aim for people with mental illness. This policy also supports the provision of different accommodation types and support services to meet diverse needs (including for those who have a high level of disability) and recognises the destabilising influence of moving through various crisis and transitional supported accommodation services.

## **Support to Achieve Mental Health Recovery and Wellbeing**

A recovery orientated rehabilitation approach will complement treatment services. Programs are required that promote: self-determination and empowerment; re-learning and skill development; striving and growth; and coping and resilience. These will assist people function successfully in the environments of their choice, by increasing their capacity to manage their condition and its impact on their lives. These programs include access to therapeutic counselling and consumer-led recovery and wellbeing and self-help programs.

This policy recognises that a strategy needs to be developed by the Western Australian mental health system to incorporate consumer-led recovery, wellbeing and self-help programs more widely as a regular component of the mental health system. The Office of Mental Health has funded a partnership approach between a group of key stakeholders to trial and promote recovery and self-help programs in Western Australia.

## **Access to Educative Mental Health and Rehabilitation Information**

Access to current and reliable information about mental health is an important aspect of recovery and rehabilitation for people with mental illness, families, friends, carers and members of the community. Important sources of information include libraries, books, flyers, self-help publications, videos and the Internet.

Interactive Internet sites should be used as an adjunct to, but not in place of, the therapeutic relationship. While the Internet may provide an opportunity to overcome distance to other sources of information for people living in isolated situations, technological difficulties and the upfront cost means the service is not yet available to all Western Australians.

This policy recognises the value of including information about mental illness, that can be accessed by people with mental illness and their families and carers, on the Department of Health website. Over time, this could include links to other sites that have been assessed against independent quality criteria.

## **Support to Achieve Physical Wellbeing**

Physical health is an important contributing factor in achieving mental health and general wellbeing. This policy recognises the importance of creating pathways and facilitating access to general health services and health promotion activities to ensure that physical wellbeing, and consequently, rehabilitation and recovery is optimised.

The absence of a range of health care services for people with psychiatric illness was highlighted through *Duty to Care. Physical Illness in People with Mental Illness* (Coghlan & others 2001). The Office of Mental Health established the HealthRight - Duty to Care advisory group to consider this report. The terms of reference of this group included



identifying the systemic changes required to meet the general health needs of people affected by mental illness.

### **Mental Health Support Services**

Mental health support services include support to undertake the full range of activities of daily living, to resolve stresses, to build and maintain relationships and to access community resources. A key issue in the provision of support services is that they are flexible to individual need both for different service types and for services at different times. The potential need for support services to be ongoing is also recognised.

Social networks and recreation activities are important for general wellbeing and can contribute to recovery and community integration. Social and recreational support services need further development to ensure that people's social and recreation needs are met in the most normalising way possible.

This policy supports the important role that family and other carers can play in a person's rehabilitation and recovery. Families need to be integrated into the recovery process, as invited by the person with a mental illness. This policy also acknowledges that for many families this caring role can represent a physical, emotional and financial challenge and, as such, there is a great need for education and support services for families and carers.

### **Skill Development Approach**

Skill development for people with mental illness is required in a number of different areas including self care, relating to others, parenting, recreation participation, pre-vocational and community access.

This policy supports the trend in Western Australia of increasingly providing living, social, recreational and pre-vocational skills within people's homes or community environments. The policy also recognises the need for increased access to parenting skills development opportunities.

### **Access to Mainstream Services and Opportunities Including: Mainstream Support Services; Recreation and Creative Arts; Education and Training; and Employment Options**

Successful rehabilitation and recovery requires that people with mental illness have access to a range of community services. Advocacy and community development to promote access to community services and resources is an integral component of a contemporary rehabilitation approach. This advocacy and community development work is required at three levels: the individual, community and interagency level.

Successful rehabilitation for people often entails linkage to mainstream community support services. Therefore, partnerships and collaboration processes should continue to be a priority. Mainstream community services relevant to people's rehabilitation can include accommodation support services, financial relief, legal services, counselling services,



relationship counselling, parenting help services, carer respite, home help services and recreation and creative arts.

Supported education and training provides the opportunity to attend education and training programs in mainstream education settings with supportive strategies. The Office of Mental Health is currently funding a project called *Pathways to Education and Work*, which aims to address the barriers faced by people with a mental illness in accessing mainstream education and employment.

While the provision of employment services is a Commonwealth Government responsibility, people with mental illness should be given the opportunity to secure a competitive job with award remuneration. Paid work for those people who are interested and able provides major economic and social advantages. Evidence shows that paid work can be achieved through the use of supported employment services that focus on securing a desirable job and supporting the person to retain it. However, employment options may not be available for all people and people should also be supported if they wish to undertake community work and other valued roles.

There is evidence that greater integration of vocational specialists into mental health services leads to better vocational outcomes. As such, this policy supports the integration of vocational specialists into Community Mental Health Teams.

### **Strategies to Complement the Direct Provision of Services**

In Western Australia, the development of competency based training, based on contemporary rehabilitation and recovery philosophy, will enhance the provision of services for people with mental illness.

This policy recognises that further collaboration between education, research and rehabilitation providers will provide a range of benefits for the further development of rehabilitation services in this state.

The development of a Psychiatric Rehabilitation consortium in Western Australia including academics, service providers, the Office of Mental Health, practitioners from a wide range of backgrounds, consumers and carers will facilitate the further development of psychiatric research and education. The Office of Mental Health will initiate stakeholder discussions to progress the development of the Psychiatric Rehabilitation consortium.

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The following issues relating to different populations are also identified.

### **Rural and Remote Issues**

Each rural and remote region of Western Australia is unique. Consequently, the barriers and opportunities for implementation of psychiatric rehabilitation services vary. There are three main issues for service provision in rural and remote areas: population needs,

geographic factors and resources. Flexibility in service models will continue to be required to ensure that appropriate services are provided in rural and remote areas of the state.

### **Issues for Indigenous People**

Indigenous people have the poorest health, social and economic outcomes in the Australian population. Consequently, the focus of a rehabilitation policy will be too narrow to encompass and address the broader mental health, general health and social wellbeing of indigenous people.

This policy gives consideration to a holistic life needs framework and the role of broader environmental, community and societal realities. Further understanding and articulation of an indigenous holistic framework and associated service models is required. Also, the relevance of the concept of the recovery journey for indigenous people needs to be examined and understood.

### **Issues for People from Culturally and Linguistically Diverse Backgrounds**

The issues and strategies highlighted in *A Transculturally Oriented Mental Health Service for Western Australia* (Mental Health Division 2001) are important in the implementation of psychiatric rehabilitation services throughout Western Australia. The Office of Mental Health will continue to implement the strategies outlined in this transcultural policy to improve mental health services for people from Culturally and Linguistically Diverse (CALD) backgrounds.

### **Issues for Children and Adolescents**

Rehabilitation services for children and adolescents need to be differentiated from those for adults or older adults due to the significantly different developmental needs of children and adolescents. There also needs to be a strong emphasis on the involvement of family, carers and support networks.

Effective integration of rehabilitation services within the child and adolescent mental health services sector is sought. Specific rehabilitation services need to be provided through child and adolescent services. These services need to take account of the developmental requirements of children and adolescents and be staffed by personnel skilled in working with children and adolescents.

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The principle aim of this policy is to set future directions and establish a vision for new and established services. This direction is based on the evidence base and emerging directions in Western Australia and from interstate and overseas. A detailed implementation plan will be developed to guide translation of this policy into specific plans, to move toward the future directions articulated in this document.

## 1.0 THE NEED FOR A COMPREHENSIVE REHABILITATION APPROACH

People who have a mental illness seek similar opportunities and responsibilities as other members of the community. These basic human rights are stated in instruments adopted by Australia including the United Nations *Declaration on the Rights of Disabled Persons*. Specific principles relating to people with mental illness are articulated in the *National Mental Health Policy* (Commonwealth of Australia 1993) and the *National Standards for Mental Health Services* (Commonwealth of Australia 1997), which states that people with mental illness have the right to an “opportunity to live, work and participate in the community to the full extent of their capabilities without discrimination”.

Psychiatric rehabilitation, or the more contemporary term, psychosocial rehabilitation, is the component of a comprehensive community-based mental health system that addresses the barriers to people with a mental illness having the opportunities to live, work and participate in community life.

At times, people with mental illness have distressing symptoms that can result in periods where it is difficult to attain and sustain good mental health. People with a persistent mental illness can also experience major impacts on their general health and wellbeing and social and economic life circumstances. This can lead to associated difficulties in life roles, impairment and participation restriction in society.

The Australian study *People Living with Psychotic Illness* by Jablensky & others (1999) found that only a relatively small number of people with a psychotic illness had utilised rehabilitation services during the previous year. In Western Australia 32.8% of those surveyed had used rehabilitation services during the previous year. Of that number only 34.6% had used these services for over six months<sup>1</sup>. Further, this study highlighted “a serious lack of community-based rehabilitation services”. The authors concluded that “meeting adequately their multiple needs – related to treatment, housing, rehabilitation and daily living support – is likely to have a much greater impact on the course of their disorders and social adjustment than the provision of anti-psychotic medication alone. This involves strengthening the partnerships between service providers in health, housing, welfare and disability support; improved community responsiveness and education; and meaningful involvement of consumers and carers” (Jablensky & others 1999a, p. 5).

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<sup>1</sup> These data were gathered within the framework of the Collaborative Study on Low-Prevalence (Psychotic) Disorders, an epidemiological and clinical investigation which was part of the National Survey of Mental Health and Wellbeing, Australia 1997-1998. The Western Australian data were provided to the Western Australian Department of Health by A. Jablensky and V. Morgan, University of Western Australia School of Psychiatry and Clinical Neurosciences. For a full report of the study, see: Jablensky & others (1999).





Janet Meagher, the Secretary of the World Federation for Mental Health, Patron of the Australian Mental Health Consumer Network and a mental health consumer says: "Believe it or not, we can learn to tolerate many of our symptoms, but we need to believe and see:

- That there is HOPE for us;
  - That we can HOPE and work towards re-integration;
  - That we can HOPE to be usefully employed;
  - We can HOPE to have a range of friends and improved quality of life"
- (Meagher 1995).

## 2.0 THE FOUNDATIONS OF A CONTEMPORARY REHABILITATION APPROACH

The World Health Organisation (WHO) has been working on a classification framework to describe disability using the components of body functions and structures (impairment), activity and participation (limitation/restriction) and environmental factors (barriers/facilitators). This framework can be used to describe the consequences of having a mental illness, from acute symptoms through to potential consequences such as poverty (see Table 1 below).

**Table 1: The Impact of a Severe Mental Illness**

	Impairment	Activity Limitation	Participation Restriction
Definitions ⇒	Problems in body function or structure such as a significant deviation or loss.	Difficulties a person may have in executing activities.	Problems a person may experience in involvement in life situations.
Examples ⇒	Hallucinations, delusions or depression.	Lack of work adjustment skills, social skills or Activities of Daily Life (ADL) skills.	Discrimination, poverty, unemployment or homelessness.

Adapted from: WHO (2002) International Classification of Functioning, Disability and Health. World Health Organisation. Geneva.

Contemporary concepts of psychiatric rehabilitation draw on frameworks such as this and incorporate personal, environmental and societal contexts. As stated by Saraceno (1997); "Psychosocial rehabilitation must work on both sides, increasing skills of the patients (individuals) and decreasing the disabling answers of society as well. A psychosocial rehabilitation approach that avoids dealing with one of these two aspects (individual disability and handicap generated by society) will be ineffective".

Contemporary thinking in psychiatric rehabilitation has also been guided by the accumulated evidence about the long term wellbeing for people with mental illness. Several long term follow up studies of people with mental illness have been key in the development of contemporary thinking in psychiatric rehabilitation. These studies have given weight to the recovery paradigm for mental health (see Farkas & others 2000, Harding 2002, Harrison & others 2001, McGorry 1992).



The recovery model makes the distinction between services provided to the person and the experience of the person. Rehabilitation interventions are the formal services that are provided to people with mental illness, while the person experiences an individual journey of recovery. Mental health practitioners and mental health services cannot create recovery for an individual, but ways of providing services can facilitate recovery (Anthony 1993, Mental Health Commission 1998).

In current rehabilitation literature there are a variety of definitions of psychiatric rehabilitation and psychosocial rehabilitation with different emphases according to philosophical tendencies and contexts. However, there is consistency of purpose and common threads through the various definitions.

### **3.0 THE INTEGRATION OF PSYCHIATRIC REHABILITATION AND TREATMENT SERVICES**

This policy document adopts the term psychiatric rehabilitation. It is defined as the formal principles and active specialised strategies within a comprehensive mental health service system, and external to the system, that supports people with a mental illness to address difficulties in their life roles and participation restriction in society. Psychiatric rehabilitation includes:

- enhancing and supporting the person's journey towards recovery and wellbeing;
- identification of the person's needs and life goals;
- providing relationship and environmental supports;
- assisting the development of skills critical for effective life management;
- increasing a person's capacity for independence and interdependence;
- successful access to community resources and opportunities; and
- participation in community life without the experience of discrimination and prejudice.

Rehabilitation for people with mental illness needs to exist within a continuum of care that includes a range of treatment services. The coordination between psychiatric treatment and psychiatric rehabilitation services is vital to ensure the best outcome for people with mental illness. Treatment and rehabilitation functions are integrated in some settings and are often provided by the same service or the same practitioner. Treatment services can be distinguished as those services that focus principally on the reduction in impairment – that is the reduction of the disorder in thoughts, feelings and behaviour. Treatment services include provision and monitoring of medication, crisis and emergency services.

As illustrated below some services are principally focussed on either treatment or aspects of rehabilitation. Others have a focus on both treatment and rehabilitation aspects.

**Table 2: Aspects of Holistic Mental Health Care and the Impact of Mental Illness**

	Treatment Focussed Services	Rehabilitation Focussed Services	
	Impairment	Activity Limitation	Participation Restriction
Medication	X		
Crises Intervention	X		
Case Management	X	X	X
Specialist Clinical Interventions	X	X	
Recovery and Wellbeing		X	X
Skill Development		X	X
Access to Community Services			X

Successful psychiatric rehabilitation is supported by:

- regular review of medication to balance the control or reduction of symptoms with medication regimes and side effects acceptable to the person;
- comprehensive treatment for all aspects of the persons physical health; and
- treatment services that support and recognise the importance of rehabilitation and the recovery journey.

Medication has an important role in reduction of psychiatric symptoms, reduced use of restraints, increased time in therapeutic activities, increase in responsiveness to other services and, more recently, reduction in medication side effects (Anthony & others 2002). However, as highlighted by McGorry (1992) “medication has its greatest direct effect at the level of impairment”. So, while the efficacy of medication is the cornerstone, further psychosocial services are essential to achieve successful rehabilitation and recovery (McGorry & others 2003).

Achieving a balance between treatment and rehabilitation philosophy and processes will be an ongoing challenge to the Western Australian mental health system. As stated by Anthony & others (2002): “All too frequently in the past, psychiatric rehabilitation either was not considered at all, considered only after the treatment had concluded, or reconsidered as an alternative when treatment had failed. Many so-called psychiatric rehabilitation programs used treatment techniques almost exclusively rather than the technology of psychiatric rehabilitation”. Edwards and McGorry (2002) recognise the importance of providing holistic care continuously and assertively during the critical years after the onset of psychosis. They also comment that this is rarely achieved “because patients are usually required to manifest negative sequelae such as relapse, suicide attempts or severe disability before care is provided in reactive and ‘too little, too late’ manner”.

Increasingly the unique contribution of rehabilitation services has been recognised by the broader mental health system. Where treatment focussed services are primarily based on the medical model, contemporary rehabilitation services have to complement treatment yet be based and shaped by a different philosophical paradigm.

#### 4.0 CONTEMPORARY REHABILITATION PHILOSOPHY AND MODELS

A number of philosophies and models are relevant to the wide range of people with mental illness. These include an emphasis on the:

- experience of the person with mental illness;
- how practitioners can best assist the person with mental illness; and
- how the system as a whole can assist the person with mental illness.

#### 4.1 The Recovery Journey

Recovery is described by Anthony (1993) as a “deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness”.

“The recovery process for people with mental illness emerges uniquely from the individual, is ongoing and non-linear with many experiencing peaks, troughs and plateaux. Recovery involves people having a personal vision of the life they want to live, seeing and changing patterns, discovering that symptoms can be managed and doing it, finding new ways and reasons for doing it and doing more of what works and less of what doesn’t. Recovery is about reclaiming the roles of a ‘healthy’ person, rather than living life as a ‘sick’ person. Recovery means growing beyond the experience of having (or being labelled with) a mental illness and developing a new meaning and purpose in one’s life. Reducing symptoms alone is not enough to ensure recovery. The process of recovery involves efforts to not only reduce unwanted symptoms of mental illness, but also to support consumers, families and carers to counter their isolation, poverty, loneliness, grief, unemployment, discrimination and anything they have lost in the wake of mental illness.

The fundamental element of recovery is hope. With hope comes the belief that changes and a better life are not only possible, but also attainable. Actively taking responsibility, self-advocating and ensuring that family and friends are educated about mental illness are all necessary to facilitate recovery.” (Mental Health Commission 1998, pp. 15-16).

Recovery is complex and occurs over a period of time. It takes time to rebuild confidence and abilities after experiencing the effects of a mental illness. Developing confidence, self respect, and a positive purpose for one’s life doesn’t occur simply because symptoms of mental illness are lessened (Anthony 1993). As noted by

The fundamental element of recovery is hope. With hope comes the belief that changes and a better life are not only possible, but also attainable



consumers and clinicians consulted during the development of this policy, recovery requires the active participation of the person with a mental illness.

People who are in a recovery process are recovering from more than just the symptoms of mental illness. Loss is a major theme of the experience of mental illness. Loss and grief are major feelings associated with mental illness.

Recovery may include understanding, accepting or overcoming:

- the effects of mental illness, such as physical symptoms, emotional fears, and feelings of being out of control;
- the trauma associated with a psychotic break and/or hospitalisation;
- negative attitudes from family members, friends, professionals, and towards oneself;
- loss of a role and positive identity in society;
- lack of enriching opportunities; and/or
- stigma and discrimination (adapted from Anthony 1993).

Early psychosis research and clinical practice has identified four recovery phases - the prodromal phase, the acute phase, the early recovery and late recovery phases. Treatment and rehabilitation interventions need to reflect knowledge of these phases. "The focus of the overall management strategy for these recovery phases is assisting clients to understand psychosis and to develop a range of skills which will enable them to achieve their goals for the future wherever practical" (EPPIC 1997).

It is recognised that there are phases within the recovery journey. The Centre for Psychiatric Rehabilitation in Boston, USA is in the process of developing the phases of recovery for consumers who have experienced the rehabilitation process. Preliminary work indicates the following phases in the recovery process (see Table 3 below).

**Table 3: Phases of the Recovery Process**

Phase 1	Overwhelmed by the disability and how the person is treated.
Phase 2	Struggling with the disability and rebuilding connections to the self, others, the environment, and meaning and purpose.
Phase 3	Living with the disability and new connections to the self, others, the environment, and meaning and purpose.
Phase 4	Living beyond the disability: authenticity, connectedness and contribution.

Source: BCRP Consulting, Inc (2001).



## 4.2 The Role of Mental Health Practitioners in Assisting the Recovery Journey

The recovery journey can be enabled by:

- the way the person is approached by the mental health system; and
- the degree to which mental health services assist people to achieve valued life roles and life satisfaction.

A person who receives the message that they have a poor prognosis through their interaction with mental health services may experience a sense of hopelessness and negativity. This may impact on their belief and hope for a future with potential for recovery and the ability to participate in everyday activities. As stated by McGorry & others (2003), “it is important for clinicians to remain hopeful of positive change rather than becoming nihilistic, and recognise that late remissions can occur despite treatment resistance”.

Whether the person is experiencing an acute hospital admission, discharge planning or disability support, they need to be encouraged by their practitioners and have hope for their future.

“What does the consumer see reflected back to him when he looks into the eyes of the doctor? Is it hope, sadness, confusion, frustration? What does the consumer hear in the underlying pitch and tonality of the doctor’s voice? Does it have a positive connotation or does the client see doom in the doctor’s eyes. Mental illness is traumatic, it comes as a shock wave to the system... I was severely chronic, not expected to work or study, or marry, or to have a relationship. I was expected to go through the revolving door of admissions for the rest of my life...” (Katsifis 2002).

The whole continuum of care will support the recovery process if all services and practitioners are oriented to person centred and recovery values. Mental health services can adopt the recovery approach in their work by establishing partnerships with the person that will empower the person, assure their rights, increase their control over their mental health and wellbeing, assist them to reach the best possible outcomes and enable them to fully participate in society.

Recovery is facilitated when mental health services:

- enable people to find the right help at the right time, for as long as they need it;
- give people the best help available, whoever they are and wherever they are;
- assist people in the context of their whole lives, not just their illnesses;
- protect consumers’ and carers’ rights and treat them with respect and equality;
- enable people with mental illness to take on competent roles;





- support people in using mental health services only when necessary; and
- can look outward and assist people to find and use other community services, supports and resources (adapted from Mental Health Commission 1998).

In addition, recovery happens when:

- services appropriately balance reduction or cessation of symptoms with medication regimes acceptable to the person; and
- mental health services are staffed by people who support the core values of this policy and are competent to assist people in their recovery.

In summary, the recognition of the recovery journey throughout the entire mental health system, rather than just through rehabilitation services, is beneficial for people with mental illness.

#### 4.3 The Strengths Model

A foundational model for contemporary mental health services is the strengths model. The strengths model offers a positive and empowering way of working with people irrespective of their level of functioning, their readiness to take up rehabilitation work, or their stage on the recovery journey. Practitioners working in all roles (including ongoing support and custodial roles) always need to present attitudes of belief in the person and the possibility of some level of recovery and rehabilitation. A strengths perspective engenders a sense of empowerment and hope, which is important to recovery and growth.

The strengths model has been increasingly recognised over the past 20 years as a way to overcome some of the limitations of problem, illness or deficit-focussed perspectives and models. The principles of the strengths model are:

- a focus on individual strengths, interests, abilities and competencies, not deficits or pathology;
- people possess the inherent capacity to learn, grow and change;
- the client directs the process;
- the client-support worker relationship is primary and essential, and is one of collaboration and partnership;
- the community is viewed as an oasis of potential resources, not as an obstacle or target for blame. The primary focus is on accessing resources available to the whole community before looking at segregated or institutionalised (disability focussed) services (Kisthardt and Rapp 1992).

The principles of the strengths model are consistent with the recovery journey. Recovery is seen as the experience of the person, whereas the strengths model is a tool used by practitioners to assist the person on their recovery journey.

The recognition of the recovery journey throughout the entire mental health system, rather than just through rehabilitation services, is beneficial for people with mental illness



#### 4.4 The Stages of Change and Rehabilitation Readiness

A relevant intervention model particular for the practitioner is the well-known Stages of Change model (Prochaska and DiClemente 1986). This model has been successfully applied in substance use fields and is increasingly being utilised in the mental health field. Awareness of the six stages of change can guide the focus of work and the nature of interventions prescribed by practitioners for rehabilitation needs or for supporting a person in their recovery process.

According to the model a person's preparedness to change is influenced by which stage of change they are in (Norcross & Prochaska 2002). The stages are:

**Precontemplation:** the person is not thinking about changing their behaviour in the next six months and may be unaware of their problem.

**Contemplation:** the person is aware of the problem, is thinking about changing in the next six months, but has not committed to action.

**Preparation [decision]:** the person may have tried to change, without success, is still thinking about change and is planning take action in the next month.

**Action:** the person changes their behaviour; for a period of one day to six months.

**Maintenance:** the person maintains behaviour change for more than six months.

**Relapse:** the person regresses to an earlier stage of change.

The knowledge of which stage the person is in influences the approach adopted in a motivational interview.

Figure 1: Stages of Change



Source: Chick (2001), based on the Stages of Change.

Rehabilitation readiness has some parallels with the change model. Readiness recognises that a person may not be in a state of readiness for change and that readiness needs to be achieved before engagement with formal rehabilitation and recovery programs.

Farkas and others (2000) describe five assumptions underpinning rehabilitation readiness. These are that readiness:

- describes the willingness and commitment to change, not capacity for change;
- changes over time;
- is environmentally specific;
- assessment involves the person during the process; and
- assessment is not intended to exclude people from the rehabilitation process.

Readiness may include readiness for change, readiness to engage in a specific program or with a specific helper and readiness to continue the ongoing process of rehabilitation.

#### 4.5 Moving Outward Toward Community Integration

The vision for contemporary psychiatric rehabilitation needs to be outward looking towards the goal of community integration. If this outward vision is held, it influences both the worker and person in their work together and guards against long-term dependencies and the continued marginalisation of people with a mental illness, and ensures people's full potential is being pursued.

With increasing confidence and function a person may move from one-on-one activities with a mental health worker through to becoming integrated into the broader community. Moving to engaging activities in the broader community may require the person to gain confidence by first engaging with services that are provided specifically for people with mental illness. In order to foster recovery and community re-integration, these specialised services need to interface with the community and promote opportunities for the person to engage with members of the wider community. Complementary strategies, such as community education, are also needed to reduce stigma and discrimination in the community and assist re-integration.

Participation in the different spheres should be shaped by the person's stage of recovery, the rehabilitation process and their personal preference. In some aspects of their life they may need a more protective and supportive environment. In other areas of their life the person can be linked straight into a mainstream service or activity (see Figure 2).

The vision for contemporary psychiatric rehabilitation needs to be outward looking towards the goal of community integration



Figure 2: Moving Outward to Broader Community Involvement



## 5.0 POLICY CONTEXT

This policy and strategic framework establishes a direction for the development of psychiatric rehabilitation services in Western Australia. Consistent with the rehabilitation definition adopted, and in order to contain the scope, there is a focus on services that address impairment, activity limitation and participation restriction. This policy is complementary to the Draft *Partnerships Create Good Outcomes: Western Australian Mental Health Future Directions 2004-2008* developed by the Office of Mental Health.

This document should be read in conjunction with the Office of Mental Health policies:

- *Supported Community Living for People with a Psychiatric Disability – A Home in the Community* (Office of Mental Health 2003), which focuses on assisting people to establish and maintain a home in the community;
- *Mental Health Promotion and Mental Illness Prevention Policy* (Office of Mental Health 2002), which includes an emphasis on developing and strengthening partnerships and reducing stigma and discrimination; and
- *A Transculturally Oriented Mental Health Service for Western Australia* (Mental Health Division 2001), which describes the issues and strategies for people from culturally and linguistically diverse (CALD) backgrounds.



## 6.0 TARGET POPULATIONS

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This policy and program is for Western Australians with severe and persistent mental illness whose life is significantly affected by their mental illness. For a specific definition of severe and persistent mental illness see Appendix One. The target group also includes those people experiencing the first episode of an illness that meet these criteria.

The acknowledgment that all people with a mental illness may have rehabilitation needs needs to be balanced with ensuring that people with the highest or more complex needs receive appropriate levels of service. To address this, service access and priority criteria need to be adopted.

This policy primarily focuses on youth and adult population groups, along with some comments about children, adolescents and families. The needs of older aged persons will be incorporated into the review of the *Policy and Strategic Directions for Mental Health Services for Older People* (Mental Health Division 1998).

The target population includes indigenous people and people from culturally and linguistically diverse backgrounds.

People with alcohol and drug issues are also included in the target population. Further work on the needs of people with a dual diagnosis is being progressed by the Office of Mental Health in association with the Drug and Alcohol Office.

## 7.0 OBJECTIVES (Overall, what are we trying to achieve?)

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Overall, the psychiatric rehabilitation program aims to:

- assist people with mental illness to optimise their quality of life including achieving residential, educational, recreational and vocational goals and aspirations; and
- support the recovery journey for people with mental illness and optimise general health and wellbeing.

## 8.0 CORE VALUES

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1. People with a mental illness can experience recovery over time and each person's journey is unique.
2. The existence of hope within the person is essential for achieving recovery and rehabilitation. Recovery is assisted when family members, service practitioners and the community support this optimistic outlook.
3. People with mental illness have strengths, personal goals and interests that must be valued and incorporated into the rehabilitation process.

4. Every person with a mental illness has the right to: live and work, as far as possible, in the community of their choice; realise their individual potential in all aspects of life including social, emotional, intellectual, spiritual and physical wellbeing; and minimise the impairment, limitations and restrictions which may result from their illness.

5. People with a mental illness have the same right as other members of the community to respect for individual human worth, dignity and privacy. They have the same right as other members of the community to participate in, direct and implement the decisions that affect their lives (unless subject to mental health legislation).

## **9.0 SERVICE DELIVERY PRINCIPLES**

### **(What key issues guide the provision of services?)**

1. Rehabilitation services are person centred. That is, the services for people are flexible and meaningful for the person and what they identify as important in their lives. Person centred services consider people's preferences, choices, life goals and roles in balance with their rights and responsibilities. They also consider people's culture, readiness, strengths, current and ongoing level of disability, variations in their level of disability, alcohol and other drug use, physical health and preference regarding family involvement in their rehabilitation.

2. Services, in conjunction with the person, identify rehabilitation needs and develop a rehabilitation plan early in a person's psychiatric care to promote recovery.

3. Empowerment is a key aspect of the rehabilitation process and people with mental illness are full partners in all aspects of rehabilitation.

4. Services support the recovery journey and foster hope for the future among all people with a mental illness and subsequent activity limitations and participation restrictions.

5. Services focus on consumer strengths and a developmental approach that works with in the person's potential and their capacity for learning, independence and growth.

6. Services encourage and facilitate community integration, foster support networks, and are primarily provided where the person lives, learns, works or socialises.

7. The program recognises the value and need for a range of services including early intervention, ongoing support and environmental modification, and recognises that integration and collaboration with a range of treatment and rehabilitation services are needed to optimise recovery and wellbeing.

8. With the consent of the person, services recognise and involve carers, family and friends in rehabilitation and the recovery journey.

9. Services are consistent with contemporary standards including the *National Standards for Mental Health Services* (Commonwealth of Australia 1997) and relevant national and state regulations.

## 10.0 PSYCHIATRIC REHABILITATION SERVICE FRAMEWORK

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This section will highlight service interventions that will contribute to Western Australia achieving a comprehensive rehabilitation service and specific principles or ways of providing services, where appropriate.

This policy proposes a service matrix built around common aspirations. Below is a table illustrating the matrix of services required to assist people achieve their aspirations. As this policy upholds values of empowerment and environments of choice, this matrix is an overview rather than an attempt to account for potential individual differences, circumstances and preferences of people.

It is acknowledged that the table illustrates the main focus of services but it is recognised that many services will have a positive influence on a range of goals. For instance, social skill development can positively influence a person's capacity to secure a job.

While all people should be given opportunities to maximise their potential, different service types will be accessed depending on the person's needs, their readiness and level of impairment.

Some people may find it difficult to utilise standard rehabilitation services. These include people who:

- experience extensive periods of being unwell;
- have developed a significant level of disability; and/or
- are faced with barriers of ageing, restrictive cognitive capacity and multi-disabilities.

People in these situations require flexible and tailored service responses. The rehabilitation goals need to be realistic yet still based on principles and practices of the strengths perspective and community integration. There should be a focus on residential, social and physical wellbeing to enhance quality of life for these people.

There are some fundamental components to an effective psychiatric rehabilitation service system. This policy explores the following components in detail:

- targeted assertive and intensive case management;
- comprehensive rehabilitation assessment approach;
- a range of supported housing options;
- support to achieve mental health recovery and wellbeing;

- access to educative mental health and rehabilitation information;
- support to achieve physical wellbeing;
- mental health support services;
- skill development approach; and
- access to mainstream services and opportunities including: mainstream support services; recreation and creative arts; education and training; and employment options.

The separation of different service types in this section does not mean that different service interventions are necessarily provided by different agencies or sectors. The important issue is that rehabilitation interventions are provided in a way that is consistent with the principles of this policy.

**Table 4: Peoples Goals and Service Interventions Focusing on that Goal**

Service Clusters	Service Interventions	People Goals						
		Wellbeing & recovery	A Home in the community	Friendships & Recreation	Relationships with family and community	Valued role or meaningful activity	Training/ work	Other opportunities similar to other members of the community
<i>Clinical Rehabilitation</i>	Case Management	X	X	X	X	X	X	
	Assessment	X	X	X	X	X	X	
	Specialised Clinical Interventions <sup>2</sup>	X						
<i>Health &amp; Wellbeing</i>	Wellbeing & Recovery programs	X				X		
	Access to educative information	X						
	Self help groups	X		X		X		
	Physical Wellbeing Services	X						
<i>Supported Housing</i>	Availability & access to the appropriate range		X					
<i>Mental Health Support Services</i>	Disability support		X					
	Psychosocial support		X	X	X	X		X
	Recreation support			X	X	X		X
	Social/friendship networks			X	X	X		
	Family & career education & support		X		X			
<i>Skill Development</i>	Residential & living skills		X					
	Social & recreation skills			X	X	X		
	Pre-vocational skills					X	X	
<i>Access to Mainstream Community Resources</i>	Community Services		X			X	X	X
	Recreation & Creative Arts					X		X
	Education & Training					X		X
	Employment						X	X
<i>Community Education &amp; Capacity Building</i>	Community Development & Stigma Reduction		X	X	X	X	X	X

<sup>2</sup> Services requiring practitioners with clinical expertise, for example cognitive behavioural therapy, psychotherapy, or rehabilitation programs directed to people with a particular mental illness.

## 11.0 TARGETED ASSERTIVE AND INTENSIVE CASE MANAGEMENT

Since mental health systems have moved to a community-based paradigm a number of identifiable models of case management have emerged. These include the Generalist/Broker Model, Clinical Case Management, the Rehabilitation Model, the strengths model, Assertive Community Treatment, and the Intensive Case Management model (Mueser & others 1998, Marshall & others 1997).

The literature surrounding the various forms of case management is complex and confounded by differing definitions and questionable model fidelity. Key reviews of this evidence base include those completed by Mueser & others (1998) and Tait (in Metropolitan Mental Health Service 2001).

The reviews and studies of the various forms of more intensive case management, or assertive case management, have indicated success in achieving a range of outcomes. Among these findings are reductions in hospitalisation, and continued engagement with mental health services (Mueser & others 1998, Preston & Fazio 2000). In addition, a recent Cochrane review of Assertive Community Treatment (ACT) found that, compared to standard care, ACT:

- keeps a higher number of people in contact with psychiatric services;
- reduces hospital admissions;
- improves accommodation, employment and satisfaction outcomes; and
- is most cost effective when utilised with patients who are high-end users of hospital services.

In the context of this Cochrane review, ACT was defined as a team-based approach that provides a high level of support. ACT team members come from a range of mental health professions. They share responsibility for the care of a distinct group of clients. ACT teams have small staff to patient ratios and try to provide a comprehensive range of psychiatric and social care in clients' homes and communities (Marshall & Lockwood 1998).

A Western Australian matched control group study by Preston and Fazio (2000) concluded that intensive case management resulted in significant reductions in inpatient service utilisation, and that this offset the increase in costs associated with increased outpatient contacts.

Consistent with the approach taken in the report *Finding a Home – Keeping a Home* (Metropolitan Mental Health Service 2001), this policy supports the targeted provision of intensive or assertive case management for people diagnosed with severe and persistent mental illness who frequently relapse, have complex psychosocial issues, are unable to



participate in the management of their illness, or are poorly engaged with mental health services.

As acknowledged by Tait (in Metropolitan Mental Health Service 2001), there is a need for further research to focus on the elements of the various case management models that are effective for different people. Given this, together with the evolving evidence base in the area, the Office of Mental Health will continue to refine its policy position in light of further research developments.

## 12.0 COMPREHENSIVE REHABILITATION ASSESSMENT APPROACH

A comprehensive rehabilitation assessment approach is also essential for effective rehabilitation. Ideally rehabilitation needs should be assessed as a part of a standard mental health assessment.

There are considerable advantages to the wide adoption of a standardised approach to rehabilitation assessment that is complementary to other standard assessments. These advantages are to both people with a mental illness and clinicians if people need to transfer to another service. Also, services can be assured of adopting an instrument that meets a number of criteria including consumer endorsement and reliability and validity criteria. Common assessment tools will also allow a process of setting explicit standards, measuring areas of medical practice against these standards and implementing any change necessary to improve patient care (Palmer 2002).

Initial and ongoing assessment processes that actively involve the person contribute to a comprehensive approach. Comprehensive rehabilitation assessment needs to be undertaken in a way that the person:

- experiences being a partner in the process;
- maximises their ownership of the process;
- is empowered and supported in achieving self-determination;
- can involve the family and treatment perspective where relevant; and
- has access to and understands the assessment.

Consultations undertaken in the development of this policy recommended the Canadian Occupational Performance Measure (COPM) for use as a comprehensive rehabilitation assessment by rehabilitation practitioners. Originally developed in Canada, the COPM has been widely used by occupational therapists throughout Australia, Canada and USA since 1995. The COPM is an effective assessment and 'therapeutic partnership' tool, which can assist clients to take a more active role in their own rehabilitation and make steps towards independence and community integration (Baptiste & Rochon 1999).

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The COPM is a client-centred, semi-structured interview, which considers the clients' beliefs, values, environment, specific roles and cultural influences. The COPM drives the therapeutic process to empower clients to identify their current priority needs and goals and then to work systematically towards achieving them.

Visual analogue scales assist clients to rate current levels of performance and satisfaction in terms of their personal, social, recreational and vocational functioning. Clinicians then assist the client to problem solve and develop logical, manageable steps towards enhancing their performance and independence in these areas. The COPM takes 30-40 minutes to administer and a follow-up session should be held after two weeks. This should be followed by ongoing monthly goal setting sessions that can be done in a group or individual setting.

Reassessment after three to six months, using the COPM tool, will detect significant changes and movement towards independence and goals. Scores can be stored electronically or kept as hard copies. Re-scoring provides valuable feedback to both clients and teams, and has been shown to be highly motivating for clients to persevere towards further goals.

The COPM was recently introduced in Bunbury and Kwinana Living Skills Centres and is currently being researched at Inner City and Fremantle Living Skills Centres. The use of the COPM as an outcome evaluation measure is gaining support at metropolitan rehabilitation services in the south west of Western Australia. Storing the data electronically enhances the use of the COPM as an outcome assessment tool as electronic data can be easily collated to determine the achievement of peoples' general and specific goals.

The Office of Mental Health will undertake a comprehensive review of available measures to determine appropriate instruments for adoption throughout the state. This review will examine a range of practitioner tools and other measures used to evaluate rehabilitation services and programs. Instruments will be assessed against criteria including:

- reliability and validity;
- training costs;
- user friendliness of the instrument;
- partnership with consumers;
- transportability across regions;
- ability to be used by a range of different clinicians;
- sensitivity to change; and
- applicability to a range of cultural groups.

## 13.0 SUPPORTED HOUSING AND FACILITY BASED REHABILITATION

### 13.1 Supported Accommodation

Stable and appropriate housing is fundamental to successful psychiatric rehabilitation and the recovery journey. Housing is a basic human need and the provision of sufficient and appropriate accommodation for many people with a mental illness remains a challenge throughout the world. Western Australia is no exception to this reality as illustrated in recent completed reports. These reports are:

- *Supported Community Living for People with a Psychiatric Disability – Living in the Community* (Office of Mental Health 2003);
- *Finding a Home – Keeping a Home* (Metropolitan Mental Health Service 2001);
- *Housing and Accommodation Platform Statement* (Western Australian Association for Mental Health 2001); and
- *Addressing Homelessness in Western Australia* (State Homelessness Taskforce 2002).

These reports and the associated consultation processes point to serious gaps in current accommodation range and availability. Clinicians, carers and consumers have repeatedly expressed the need for a range of supported accommodation alternatives. This range of supported accommodation services includes:

- clinically supported short term accommodation – these can be used as an alternative to hospital and provide a high level of support;
- supported housing programs for people with special and complex needs, including those with dual diagnosis;
- independent housing with different levels of mobile support according to need. This includes increased support for people with more complex needs and capacity for brokerage and wrap around support services. Housing options where small numbers of people can live close to one another for social linkage and support has also been identified as an important option;
- small groups of homely style accommodation for people who cannot live independently; and
- flexible accommodation funding for rural and remote areas – known as the Flexible Accommodation Program.

This policy endorses establishing a real home in the community as the ultimate aim for people with mental illness. This may include living alone, or with others in cluster or shared housing. This policy also supports the provision of different accommodation types and support services to meet the diverse needs of people and recognises the destabilising influence of moving through various crisis and transitional supported

Stable and appropriate housing is fundamental to successful psychiatric rehabilitation and the recovery journey



accommodation services. This evidence is reviewed in *Supported Community Living for People with a Psychiatric Disability – Living in the Community* (Office of Mental Health 2003).

This policy recognises that a key issue for people with mental illness living in their own home is the provision of appropriate levels and types of support. This support needs to be provided within their home and community and be flexible to accommodate their changing needs. This ensures that people are supported appropriately and that they are able to remain in their home when their level of disability fluctuates or changes over time.

This policy recognises that for people who need medium to high levels of support having a home in the community is only viable with an adequate level and range of support. This will require the expansion of support services throughout the state. Consistent with *Finding a Home – Keeping a Home* (Metropolitan Mental Health Service 2001), it is acknowledged that the gap between current accommodation services and this ideal of each person having their own home in community may require the development of alternative service models. These alternative services may also contribute to the appropriate use of inpatient services in the short term.

The policy recognises the importance of standards and standards monitoring in relation to the accommodation services. As indicated in *Supported Community Living for People with a Psychiatric Disability – Living in the Community* (Office of Mental Health 2003), the *National Standards for Mental Health Services* (Commonwealth of Australia 1997) have been adapted for non-government providers. In addition, the Office of Mental Health will continue to work collaboratively with agencies that have responsibility for the monitoring of standards.

### **13.2 Facility Based Rehabilitation**

A key issue that intersects with supported housing is the provision of facility based or residential rehabilitation. These are facilities where people live for a period of time, with an emphasis on rehabilitation services during their stay. This can be in a specific facility based rehabilitation service or in conjunction with treatment services such in step-down or intermediate care facilities. It is beyond the scope of this policy to discuss the treatment aspects of such services.

In comparison with hospital settings, there is some evidence to show that facility based rehabilitation can be an effective and cost efficient alternative (Hawthorne & others 1999, Paterson 2002, Metropolitan Mental Health Service 2001). However, there are limitations to facility based rehabilitation.

Consistent with the principles of this policy and the *National Standards for Mental Health Services* (Commonwealth of Australia 1997), rehabilitation services are best provided

where the person lives, learns, works or socialises. Residential rehabilitation models which require residents to move onto another service within a defined time period may be operating in contrast with this principle, as they may hinder people developing skills relevant to their community and home. Further, facility based rehabilitation requires the person to re-learn skills when moving onto their next residential placement. The disadvantages of this movement through a continuum of accommodation services are well documented (Office of Mental Health 2003, Paterson 2002).

The alternative to residential rehabilitation is supporting people in securing a home and providing the support and rehabilitation necessary within the home. Given the episodic nature of mental illness, this support and rehabilitation needs to be highly flexible. Such a choose-get-keep model of housing, support and rehabilitation facilitates integration of the person within their community. A potential limitation of the choose-get-keep model is the cost and staff time associated with providing ongoing support for people with high support needs. Possible compromises include the provision of ongoing support to small groups of people accommodated in close proximity to one another.

In some instances, facility based rehabilitation models have been used for people moving from the long term institutional settings to the community. There is debate within the sector about the appropriateness of such services and it is recognised that these services are not appropriate for all people leaving institutions (Farhall & others 2000). Consistent with the emphasis on community integration, this policy supports individualised planning for people who are leaving long term institutional settings, to ensure that accommodation and support are appropriate to the persons needs.

#### **14.0 SUPPORT TO ACHIEVE MENTAL HEALTH RECOVERY AND WELLBEING**

A recovery orientated rehabilitation approach will offer people therapies and programs that complement medical psychiatric treatment. This requires a range of interventions, from evidence-based therapies provided by specialist mental health professionals, to consumer-led mental health recovery and self-help programs. These need to be available throughout the service system continuum including hospital settings, structured clinical sessions in out-patient settings and community-based settings.

In general, programs are required that promote self-determination and empowerment, re-learning and skill development, striving and growth, and coping and resilience. These will assist people to function successfully in the environments of their choice by increasing their capacity to manage their condition and its impact on their lives.

Access to therapeutic counselling services is important, as many people with a major mental illness carry unresolved childhood and family experiences. For some people, their





poor mental health state is related to childhood and adult abuse and access to skilled therapeutic services is vital for healing and recovery. The majority of people with major mental illness are on low income, so accessing private therapists is not a viable option, and alternate community-based counselling services are required.

Recovery, wellbeing and self-help programs are best operated with consumers as facilitators, trainers and peer support workers where they can exchange their wisdom and act as mentors to others on the journey of rehabilitation and recovery.

There is now considerable contemporary health and social science literature on recovery and wellbeing that can be drawn on in the development of programs. There is also a proliferation of writings from consumers who have made the journey of recovery and have shared their story and insights (Alaska Mental Health Consumer Web 2003, recovery411.com 2002, Copeland 2002a).

There are a number of recovery and self-help programs available through Australian and international networks that emphasise psychiatric rehabilitation and mental health recovery. One program employed or adapted in a number of agencies around the world includes process and phases of recovery; increasing knowledge and control; managing life stressors; enhancing personal meaning; building personal supports; and setting personal goals (The Centre for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University). Another self-management program known as WRAP (Wellness Recovery Action Plan) is also readily accessible and is increasingly being taken up through international networks. This program assists people in monitoring and managing their symptoms and is a simple structured self-help guide. This program is being used to complement other psychiatric treatment programs (Copeland 2002).

Western Australia has a limited number of consumer-led recovery and well-being programs that are integrated into the mental health system. There is also very limited public funding for self-help groups. A strategy needs to be developed by the Western Australian mental health system to incorporate consumer-led recovery, wellbeing and self-help programs more widely as a regular component of the mental health system. The Office of Mental Health has provided seed monies for the trial of a consumer-led recovery program. WRAP was successfully trialed in Perth during 2003 and 2004. Facilitators for the WRAP trial have been drawn from the local consumer movement and supported by Ruah Inreach.

#### **14.1 Access to Mental Health and Rehabilitation Information**

Access to current and reliable information about mental health is an important aspect of recovery and rehabilitation for people with mental illness, families, friends, carers and members of the community. Important sources of information include libraries, books,

flyers and self-help publications. Videos may be an important source of information for people who have difficulty reading.

This policy recognises the increasing importance of technology as a source of information about mental illness, particularly as increasing numbers of people become computer literate. The Internet can be a useful source of information about mental illness treatment and rehabilitation. For some people it may also be an option for accessing self-help services and onsite programmes to enhance therapeutic goals.

In January 2000, at a TheMHS summer conference, Ron Mandersheid outlined the explosion of interactive sites offering psychotherapy in the USA, with over 1000 active sites at that time. Some were voice recognition programs. The privacy and efficacy issues are enormous, as are the risks of vulnerable people providing their personal details in the interests of therapy without knowing the credentials or motivation of the site creator. Nevertheless there are programs developed that have been evaluated and are effective.

While acknowledging the potential value of interactive sites, it is stressed that they should be used as an adjunct to, but not in place of, the therapeutic relationship. It is also recognised that, while the Internet may provide an opportunity to overcome distance to other sources of information for people living in isolated situations, technological difficulties and the upfront cost means the service is not yet available to all Western Australians.

A critical issue in this service type is ensuring that people access reliable information amongst the vast array of sources. As described by Rodrigues (2000), "both physician and patient must become aware of what information is available, the source of the information and the intended audience. Online information that differs significantly from that prescribed by the physician may result in unanticipated consequences". This policy recognises the value of including information about mental illness that can be accessed by people with mental illness and their families and carers, on the Department of Health website. Over time, this could include links to other sites that have been assessed against independent quality criteria.

#### **14.2 Support to Achieve Physical Wellbeing**

In addition to the provision of psychiatric rehabilitation services, physical health is an important contributing factor in achieving mental health and general wellbeing.

The absence of a range of health care services for people with psychiatric illness was highlighted through *Duty to Care. Physical Illness in People with Mental Illness* (Coghlan & others 2001). This report concluded that people with mental illness have "poor health outcomes

**Physical health is an important contributing factor in achieving mental health and general wellbeing**



across a very broad spectrum of physical diseases". Key recommendations from this report include smoking prevention programs; further services for addressing alcohol and drug use; and integration of physical and mental health care for people with mental illness.

The Office of Mental Health has established the HealthRight - Duty to Care advisory group to consider this report. The terms of reference of this group included identifying the systemic changes required to meet the general health needs of people affected by mental illness. This advisory group includes the following representatives: General Practice (Divisional and College representatives); mental health clinical services (metropolitan and rural); the psychiatric hostels sector; the Office of Mental Health; the Office of the Chief Psychiatrist; the consumer sector; the carer sector; the Commonwealth Department of Health and Ageing; the Joint Services Development Unit; non-government sector; and the health promotion sector.

This policy recognises the importance of creating pathways and facilitating access to general health services and health promotion activities for people with mental illness, to ensure physical wellbeing and, consequently, rehabilitation and recovery is optimised.

While systematic change will take some time, rehabilitation practitioners can enhance physical wellbeing through:

- encouraging people to access general and dental health-care for periodic check ups;
- encouraging access to specialist health services as required;
- educating and supporting healthy behaviours such as exercise, good nutrition, smoking cessation and sun protection; and
- facilitating access to services that support healthy behaviour such as gyms and other exercise facilities, smoking cessation classes or other health promoting activities.

## **15.0 MENTAL HEALTH SUPPORT SERVICES**

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The Office of Mental Health funds mental health support services to assist people to live in the community. These services include support to undertake the full range of activities of daily living, and support to build and maintain relationships and access community resources. Disability, psychosocial, recreational, respite, and carer support are terms used to describe particular types of support services currently funded by the Office of Mental Health. Currently, these services are mainly provided by non-government providers, although the shortage of non-government providers in some rural and remote regions may require alternative providers to be found in the short term.

Mental health support services form a complementary role to both psychiatric treatment services and specialised rehabilitation and recovery programs. For example:





- disability support services can encourage and reinforce skill development;
- psychosocial support services can work on increasing people's capacity for independence in community living; and
- social and recreation support programs can enhance people's participation skills.

While people need the opportunity to maximise their independence, some people will continue to need support to live in the community. Therefore, support services need to be available on the continuum of support from ongoing disability support to psychosocial support, to address complex needs.

A key issue in the provision of support services is that they are flexible to individual need, both for different service types and for services at different times. People's support needs may change over time depending on their mental health state and their stage of rehabilitation and recovery journey. For example, some people will require ongoing support in maintaining their home. Others require short-term assistance in negotiating access to a mainstream service to resolve a stressful situation. Another person may only require services when they are experiencing a period of relapse.

The potential need for support services to be ongoing is recognised. However, this should be balanced with not maintaining or creating unnecessary dependence on the service and encouraging independence where possible. Opportunities for skill development need to be acknowledged and recognised by the support provider. In this respect, these support services need to be part of a holistic developmental care plan developed for each person. This care plan is the responsibility of the mental health service, general practitioner or private psychiatrist and needs to be developed in consultation with the person and other service providers.

The further development of mental health support services is detailed in the policy, *Supported Community Living for People with a Psychiatric Disability – A Home in the Community* (Office of Mental Health 2003). This includes the Office of Mental Health intention to increase the availability of higher levels of support so that people with higher support needs can live in the community.

### **15.1 Social and Recreational Support Services**

Social networks and recreation activities are important for general wellbeing and can contribute to recovery and community integration. Social and recreational support services need further development to ensure that people's social and recreation needs are met in the most normalising way possible. The goals need to be about building social links and friendships, and participation in community-based recreation beyond the mental health system.

**Social networks  
and recreation  
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important  
for general  
wellbeing**

Social isolation and marginalisation are significant issues for people with mental illness (Jablensky & others 1999, Anjos 2002). Leisure and recreation is also usually an important aspect of most people's lives. For people who have limited employment opportunities, use of leisure time is very significant. However, low incomes mean affordability can be an issue in accessing recreation opportunities.

The full potential of recreation needs to be supported by recreation workers, who can work with issues associated with mental illness and who are able to enhance people's exposure and access to a variety of recreation pursuits in the community. Rehabilitation workers need to be mindful of assessing whether people actually need skill development in social relationships, building friendships and social anxiety management strategies, or just need more opportunities to meet other people. Program goals should reflect these differences. Other issues to be considered are people who may have dependent children, particularly children under school age, as this may affect the person's availability to attend programs outside the home. Also, social and recreational activities need to be appropriate for each person. For example, younger people may feel uncomfortable being involved in activities with groups of older ages and may be interested in different activities, and people from CALD backgrounds may have cultural based differences in what may be considered appropriate social and recreational activities.

A contemporary approach to mental health rehabilitation in the social and recreation sphere of people's lives needs to avoid programs and interventions that reinforce institutionalised dependency on the mental health practitioners and isolation from the broader community life.

Service strategies need to:

- maximise participants input into the process of planning, implementing and reviewing programs;
- operate activities in a manner aimed at including opportunities for confidence building and skill development;
- provide training for people to become independent participants, for example assisting with social anxiety strategies, relationship skills, and transport training;
- plan activities around enhancing community linking and use of broader community facilities and resources;
- pursue activities that are most likely to be followed up independently by individuals and are sustainable in their lifestyle;
- facilitate peer and interest groups and networks, as this assists independent participation and sustainability;
- provide links to existing opportunities that are not dependent on mental health professionals, for example self-help networks and local community groups; and

- employ strategies with people that strengthen their existing social network, for example family, friends, neighbours and informal community relations.

In rural and remote settings social linking can be a challenge. For the larger centres, access to meeting places is important. There is a preference that meeting places are located within community facilities rather than at locations set apart from the community life. The Internet, where available and accessible, can provide some opportunities for social communication.

## 15.2 Family and Carer Support and Education

Family and carer support and education is another mental health support service that needs development in Western Australia.

Family is defined, in a broad sense, to include members of the consumer's chosen family and support network including relatives (for example partners, children, siblings, parents) and other significant others (for example carers, advocates, neighbours, ex-partners, friends) who are actively involved in the consumer's life. This can include:

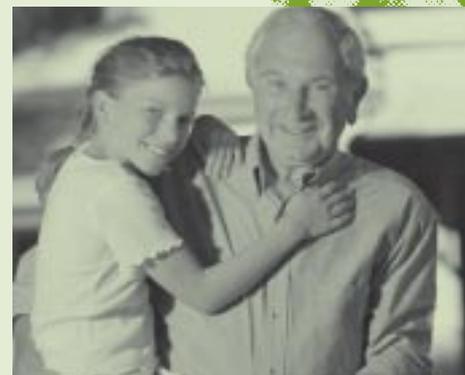
- adults from the consumer's chosen family;
- young people who have a parent or sibling with a mental illness;
- aging parents and carers;
- Aboriginal and Torres Strait Islander families; and
- families from culturally and linguistically diverse backgrounds (Metropolitan Mental Health Service 2001a).

For some people with mental illness, families have an important role in the recovery process as they can play a role in the person's life over an extended period, possibly a lifetime. Education for families is important to ensure that families can support the rehabilitation and recovery journey.

The recovery model is of value to families in addressing their uncertainty about the outcome of the illness. Recovery encourages realistic hope that the "family and the person with the psychiatric disability will find a way to rebuild the personal, social, environmental, and spiritual connections" (Spaniol & others 2000).

The experience for families, when a family member becomes psychiatrically unwell, can be traumatic and result in major role changes, which family members may be ill prepared to deal with. The adjustment process can take years and the lack of clarity about the outcome of illness can result in family members cycling through hope and despair. It is important to recognise that families will experience their own adjustment process and for families to be supported through this process.

For some people with mental illness, families have an important role in the recovery process



This policy supports the important role that family and other carers can play in a person's rehabilitation and recovery. Families need to be integrated into the recovery process, as invited by the person with a mental illness. This policy also acknowledges that, for many families, this caring role can represent a physical, emotional and financial challenge. It also recognises that there is a great need for education and support services for families and carers throughout Western Australia.

There are a number of separate issues when the family member who has a mental illness is a parent. These families need a range of services, such as practical and parenting support and plans for when one or both of the parents are unwell.

The issues for children who have a parent with a mental illness were identified through the *Pathways to Resilience: Children of Parents with a Mental Illness Project Report* (Office of Mental Health 2002). Further development of appropriate responses for these children is currently being overseen by the Children of Parents with a Mental Illness Interagency Statewide Strategic Committee, which has been established to address this issue.

## 16.0 SKILLS DEVELOPMENT APPROACH

Addressing the skill development needs of people with a serious and persistent mental illness is a key component of the rehabilitation process. As stated by Hughes (1994): "The goal of all psychiatric rehabilitation programs is to restore each person's ability for independent living, socialisation and effective life management. Serious and persistent mental illnesses can result in significant functional deficits that affect a person in every aspect of his [/her] life. Effective psychiatric rehabilitation services are aimed at minimising these impairments in functioning and role performance, and restoring the individual to maximum functioning".

Skill development for people with mental illness is required in a number of different areas including self care, relating to others, and parenting, recreation participation, pre-vocational, and community access.

Basic principles in approaching person's skill development needs are:

- the focus must relate to the person's life goals and aspirations and build on their existing strengths and skills;
- assessments and focus of work needs to incorporate the different environments that people find themselves in: residential, social, recreational, educational and vocational;
- the importance of linkage to mainstream skill development opportunities where possible and relevant; and
- the importance of research and continuous service improvement to enhance service capacity in effective skill development approaches.





This policy recognises the literature and clinical experience that points to the advantages of teaching skills within the environment in which they will be practiced. Contemporary services to develop these skills are provided to the person in their chosen environment to ensure skills are transferred to the appropriate environment and are maintained in the longer term. This principle is also endorsed in *National Standards for Mental Health Services* (Commonwealth of Australia 1997) which states: “The setting for learning or the re-learning of self care activities is the most familiar and/or the most appropriate for the generalisation of skills acquired. Notes and examples: In the consumer’s own home, the consumer’s local shops, transport”.

The provision of skills within people's natural environments also enables people to learn skills that are adaptable across new situations, for example interacting with others in a range of different situations.

Some skills, such as relating to others, are appropriate for learning in a group where the skills can be practiced with other members of the group. These groups can also provide an opportunity for modelling community integration if conducted within community venues.

This policy document supports the trend in Western Australia, where there is increasing provision of living, social, recreational and pre-vocational skills within people’s homes or community environments. These more contemporary approach also recognise the need for:

- client-centred assessment processes with their active participation;
- the need to build services programs around the person rather than placing the person into a pre-existing program;
- the need for regular reviews and client feedback; and
- the need for continuity of rehabilitation services when people enter inpatient services.

For some people with mental illness parenting is a significant life role for which they wish to develop relevant skills. This requires rehabilitation services to provide opportunities for parents to address their parenting issues through parenting support groups, parent education and training (Mowbray & others 2001). These skill development opportunities can be provided through mental health services or in partnership with existing parenting services.

Pre-vocational skills (also known as pre-employment skills) can include a range of individual and group activities. These services recognise the disruption that mental illness can have on the development of vocationally related skills and build on the basic skills that are required prior to undertaking a work trial or placement. These skills can include:



punctuality, concentrating for the duration of the task, appropriate dress, appropriateness in conversation and behaviour; social skills and manners, following instructions, initiative, cooperation skills, literacy and numeracy, and managing the effects of medication. Some programs also include access to information and vocational advocacy and support.

## 17.0 ACCESS TO MAINSTREAM SERVICES AND OPPORTUNITIES

Advocacy and community development, to promote access to community services and resources, is an integral component of a contemporary rehabilitation approach. The advocacy and community development work required has three levels: the individual, community and interagency levels.

At the individual level, mental health rehabilitation workers need to perform roles of advocacy and referral for people to mainstream, health, support, recreational, education, and employment services. There is a need for community development linkage work to occur so that people with mental illness can live in the community with similar opportunities as other members of the community. This includes:

- identifying people's needs, interests and goals with them;
- identifying barriers (personal and structural) to access; and
- providing advocacy, facilitation and support roles to enable access to opportunities.

At the community level, work needs to occur to build local communities' capacity to respond appropriately to mental illness and address discrimination and stigma in the community. This includes stigma reduction strategies and community capacity building.

The role of public health services, in conjunction with mental health services, in community development and stigma reduction is highlighted in the *Mental Health Promotion and Mental Illness Prevention Policy* (Office of Mental Health 2002). While recognising the importance of this work, there is pressure for mental health practitioners to undertake direct treatment and rehabilitation work. In addition, some aspects of community development and stigma reduction require access to specialist community development and educative skills.

At the interagency level, a holistic approach is required to address structural disadvantage in access to general health care, housing, education and employment opportunities.

The Office of Mental Health will continue to advocate on behalf of people with mental illness. This advocacy includes facilitating other agencies to adopt inclusive policies and practices, minimising the impact of financial and other barriers on access by people with mental illness, and developing statewide interagency agreements.

## 17.1 Access to Mainstream Support Services including Recreation and Creative Arts

No sector can provide the complete range of services that people require for their rehabilitation from a mental illness. Successful rehabilitation for people often entails linkage to mainstream community support services. Therefore, partnerships and collaboration need to continue to be a priority.

Mainstream community services relevant to people's rehabilitation can include: accommodation support services, financial relief, legal and counselling services, relationship counselling, parent help services, carer respite, home help services, and recreation and creative arts.

Mental health workers need to build their knowledge of community services resources and proactively assist individuals in securing successful access. It is important that any tentativeness or discrimination by mainstream community agencies, to provide services to people with mental illness, is addressed with advocacy and education.

People with mental illness have a wide range of recreation interests and can participate in a number of different ways including:

- activities with a mental health professional, for example creative art with occupational therapist or a recreation activity with mental health psychosocial support worker;
- activities with a community agency funded to provide a program for people with a psychiatric disability, for example disability art access group or social club or network; and
- activities within the broader community, for example local craft classes, TAFE arts course or membership of tennis club or ten pin bowling club.

Access to these recreation activities can be facilitated by:

- accompanying people in the initial attendance of a community group;
- facilitating the forming of small peer groups with similar interests to join a community activity;
- forming a team to join a local sporting group, for example indoor volleyball;
- forming a walking group or bike group and advertise in the local paper for other people from broader community to join;
- approaching a local existing group, for example craft or tennis club and ask for volunteers to assist peoples' entry to the group, for example low cost classes to share skills; and
- forming an inter-agency relationship with local sport and recreation agencies for the benefit of people with mental illness.

Creative arts can be both a leisure pursuit and an income earning opportunity for people. Some art mediums can more directly assist

Successful rehabilitation for people often entails linkage to mainstream community support services



participants in their healing and recovery journey. One such example is creative writing or journalising. As described by Finlayson (2003), during the past ten years, an increasing number of studies have demonstrated that when people write about emotional experiences, significant physical and mental health improvements follow (Pennebaker 1997). Outcomes have ranged from a decrease in medical centre visits, through to reporting more positive moods (Pennebaker & Beall 1986), increased chances of reemployment after job loss (Spera & others 1994) and to a decrease in physiological symptoms in chronic asthma and rheumatoid arthritis sufferers (Smyth & others 1999).

Throughout the world, creative art forms have proven to be a significant medium through which disadvantaged people can gain the benefits of meaning and expression, healing, social engagement, community participation, income-supplementation, and growth in confidence and self-esteem.

## **17.2 Access to Education and Training**

For some people, commencing or resuming education or training can be a step in the direction of reclaiming a valued social role, or building hope for a future with opportunities (Farkas 1996 in Anthony & others 2002). Supported education and training provides the opportunity to attend education and training programs in mainstream education settings with supportive strategies.

Rehabilitation involves setting goals and taking steps, and this is very relevant in the sphere of education and training. There are people today with mental illness taking mainstream TAFE and university courses. Their experiences need to be understood so supportive strategies can be developed for people to successfully complete courses at these levels. A recent study completed at the University of Melbourne examined the learning support needs of tertiary students with a psychiatric disability. The study identified a range of possible strategies to support people with mental illness including study skills help, additional tutorial assistance for specific subjects, availability of a peer mentor or study buddy and more flexibility in students' course timetables (McLean & Andrews 1999).

Facilitating access to education and training opportunities for people with mental illness has implications at each of the three levels of advocacy and community development: individual, interagency and community.

At the individual level, the focus is on determining what is the best starting point for a person's learning environment. For some people, one-on-one tuition to build computer or written presentation skills is the best way to build their confidence. Learning and community centre courses are a good starting point, as they provide an informal and friendly learning environment. For others a tailored pre-vocational course for people with psychiatric disabilities or a local TAFE general bridging course may be more suitable.





At the interagency level the focus is on making mainstream education and training opportunities accessible, friendly, supportive, and inclusive to people with a mental illness. People with mental illness may have different requirements to people with other disabilities (Danley & others in Anthony & others 2002). There is a need to work with disability officers, teachers and agencies within the education sector to advise about the needs of people with mental illness. This will ensure that the disability support systems, such as Disability Services at the tertiary level, which currently exist in the sector are able to appropriately attend to the needs of people with mental illness, both in commencing and continuing their education or training.

At the community level, there is a need to address the structural barriers that low income earners experience in relation to accessing education, for example cost and transport. There is also the important task of building the community's understanding of people with a mental illness, by addressing prejudice and misconceptions.

The Office of Mental Health is currently funding a project called *Pathways to Education and Work*, which aims to address the barriers faced by people with a mental illness in accessing mainstream education and employment. The Office of Mental Health will continue to promote access to education and training for people with a mental illness in conjunction with government departments and education and training providers.

### **17.3 Access to Employment Options and other Valued Roles**

People with mental illness should be supported in their wishes to undertake valued roles including employment, volunteering and community work. These programs should be provided in a way that maximises people's community integration and provides meaningful roles.

Paid work for those people who are interested and able provides major economic and social advantages. People with mental illness should be given the opportunity to secure a competitive job with award remuneration. As highlighted by Harrison & others (2001) and McGorry (1992), people can continue working even when other life roles or functions are disrupted by their mental illness. People with mental illness who may not exhibit functioning in one area may be ready to secure a job and may be successful in doing so. Given this, it is important that all people are given the opportunity to secure a job if this is one of their goals.

A comprehensive review of 18 randomised control trials of vocational rehabilitation was completed by Crowther & others in 2000. In this Cochrane Review, prevocational training was defined as an approach in which participants undergo a period of preparation before seeking competitive employment. This could involve either work in a sheltered environment or Clubhouse, or some form of pre-employment training or transitional employment. In Western Australia this is also called supported employment. Supported

**People with mental illness should be supported in their wishes to undertake valued roles**

employment was defined as any approach to vocational rehabilitation that attempted to place clients immediately in competitive employment. This may include a preparation period of less than one month. In Western Australia this is called open employment.

This review concluded that supported employment (open employment) was the most effective in achieving full or part time positions in ordinary work setting at market remuneration rates. This review also concluded that there was no evidence that pre-vocational training (supported employment) was any more effective in helping clients obtain competitive employment than standard community care (i.e. the usual psychiatric care for patients without any specific vocational component).

Consistent with the evidence base, this policy supports choose-get-keep and-leave methods of providing supported employment as best suited to facilitate recovery. As the name implies, this way of providing services focuses on securing a job that the person desires and supporting them in retaining it. Recently, the need for people to move on from any particular job has been recognised and, consequently, support is also provided to people when the person wishes move on from a job. This way of providing supported employment has advantages in ensuring that the person:

- is able to chose the job they want;
- has the opportunity to be paid award wages;
- learns appropriate skills in the environment where they need to be applied; and
- is integrated into a workplace with a range of other people.

Within the supported employment (open employment) framework differing levels of effectiveness can be obtained. Research by Bond (1998) has shown empirical support for six principles that impact on vocational outcomes:

- competitive employment as the goal;
- rapid job search (i.e. direct assistance finding jobs as opposed to prevocational training);
- integration of vocational rehabilitation and mental health services;
- attention to consumer preferences;
- continuous and comprehensive assessment; and
- time – unlimited support (i.e. support can be continued indefinitely).

As there is evidence that greater integration of vocational specialists into mental health service delivery leads to better vocational outcomes (Drake & others in Bond 1998), this policy supports the integration of vocational specialists into Community Mental Health Teams. As described by Bond (1998) this integration includes "the establishment of formal and informal relationships between vocational and mental health staff members, with the intention of facilitating mutual respect and communication between case managers and employment specialists, as well as shared decision making and coordinated planning and





interventions”. To achieve this integration it is recognised that a number of issues need to be addressed, including client confidentiality.

The provision of employment services is currently a Commonwealth Government responsibility. Western Australia has only one specialised psychiatric open employment agency, with a waiting list of several years. In addition, people with mental illness experience difficulty in accessing the generic supported employment and job placement agencies provided in the state through the Commonwealth Government.

The Office of Mental Health will continue to liaise with the Commonwealth Government about appropriate levels of supported employment services. The Office of Mental Health will also support strategies to ensure that people with mental illness have access to generic supported employment and job placement agencies.

## **18.0 STRATEGIES TO COMPLEMENT THE DIRECT PROVISION OF SERVICES**

The following systemic issues that affect the delivery of rehabilitation services have been identified. Addressing these issues will enhance the delivery of rehabilitation services throughout Western Australia.

### **18.1 Balancing the Provision of Treatment and Rehabilitation Services**

A major issue identified by both metropolitan and rural and remote practitioners is the need to balance the funding and provision of treatment and rehabilitation services. For rehabilitation staff working within a combined treatment and rehabilitation service, crisis work can take priority. Staff are often asked to participate in the provision of treatment services (such as emergency rosters and duty officer cover) at the expense of providing rehabilitation services. This issue arises both for workers who are identified as specific rehabilitation workers, as well as for those who are undertaking rehabilitation as part of a broader case management role.

This tension can also be reflected in the movement of funds from rehabilitation services, particularly during service restructuring. As with other specialist services, the Office of Mental Health will ensure that resources currently allocated for rehabilitation services are maintained during any redevelopment of services.

The identification of discrete rehabilitation workers minimises the impact of treatment service demands on the delivery of rehabilitation services. This practice, however, may have limited applicability in rural and remote regions as it may require both treatment and rehabilitation workers travelling considerable distances to provide services within a community.

## 18.2 Workforce Training and Education

A significant issue is the need for increased specialisation and training of some people who provide mental health rehabilitation services in Western Australia. In some other states the need for rehabilitation skills has been recognised through the provision of specific training programs. In Western Australia, the development of competency based training, based on contemporary rehabilitation and recovery philosophy, will enhance the provision of services for people with mental illness.

The development of appropriate training needs to occur at several levels. Firstly, there is the need to ensure that contemporary philosophy is included in undergraduate and postgraduate training for the full range of mental health professions. Secondly, programs need to be developed to ensure that support workers, who may not have tertiary qualifications, are also provided with opportunities to develop knowledge, skills and attitudes that are consistent with contemporary rehabilitation philosophy.

Recovery oriented skills and attitudes are also required by mental health workers throughout the sector. This need has been recognised in the *National Practice Standards for the Mental Health Workforce* (Commonwealth of Australia 2002). This policy endorses this move toward the recognition of the importance of these skills and attitudes among mental health practitioners.

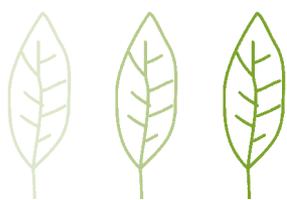
## 18.3 Research

This policy recognises that further collaboration between education, research and rehabilitation providers will provide a range of benefits to further the development of rehabilitation services in this state. These benefits include the enhancement of teaching and research, and the gathering together of research expertise to expand the evidence base.

Ongoing research will promote the recognition of rehabilitation and recovery as a specialist discipline and promote service accountability. Through working together researchers and practitioners can evaluate and improve the services offered. The development of a Psychiatric Rehabilitation consortium in Western Australia which includes academics, service providers, the Office of Mental Health, practitioners from a wide range of backgrounds, consumers and carers, will facilitate further development of psychiatric research and education. The Office of Mental Health will initiate stakeholder discussions to progress the development of the Psychiatric Rehabilitation consortium.

## 19.0 RURAL AND REMOTE ISSUES FOR CONSIDERATION IN THE IMPLEMENTATION OF THE POLICY

As the provision of services in the metropolitan area was the focus of the *Recommendations for Reform 2000* (Metropolitan Mental Health Service 2001a),



a particular emphasis has been placed on ensuring this policy appropriately represents the circumstances in rural and remote areas. To achieve this, the working group included a rural and remote representative who regularly consulted other rural and remote coordinators. In addition, a videoconference consultation was held with representatives from the North West, South West and Coastal and Wheatbelt regions in January 2003. An outline of the policy was also presented at the 2002 Rural and Remote conference to raise awareness of the policy development process and stimulate discussion about the policy direction.



Throughout initial consultations, rural and remote practitioners welcomed and supported the policy direction and expressed willingness to continue to work toward the service principles contained in this policy. The consultations highlighted some significant issues in the implementation of comprehensive rehabilitation services. Representatives also highlighted innovative ways to overcome these issues and move toward providing mental health services consistent with the principles of this policy. Support for the recovery model was subsequently indicated in *Rural and Remote Mental Health Services Working Party: Report for Western Australia's State Mental Health Strategic Plan 2003-2008*.

Each rural and remote region of Western Australia is unique. Consequently the barriers and opportunities for implementation of psychiatric rehabilitation services vary. While these issues are interconnected the issues raised included those of:

- population needs, such as the unique needs of Aboriginal and Torres Strait Islander populations, farming families and fly-in-fly-out communities;
- geographic factors, including the distances between communities and difficulties in accessing some remote communities; and
- resources, including the limited community services and resources in some areas and difficulties in recruiting and retaining staff in some regions.

A significant issue for rural and range regions is the unique needs of Aboriginal and Torres Strait Islander people and communities. In the North West, Aboriginal and Torres Strait Islander people make up a significant percentage of mental health service clients. Aboriginal and Torres Strait Islander workers within mental health teams have been beneficial in addressing the needs of these people. As well as being role models and advocates for Aboriginal and Torres Strait Islander people, these workers have become essential for education and training of mental health staff, other service providers and the local community.

A key issue for some rural and remote regions is the need to prioritise the provision of crisis and acute mental health care when staff are limited. Consequently, the provision of rehabilitation services takes second place when crisis and acute situations arise. The potential solution of having specialist dedicated rehabilitation services or workers may not be

advantageous in rural and remote areas, due to the duplication of travel time and costs to different communities. This issue can be exacerbated by recruitment and retention difficulties, resulting in unfilled positions. In addition, the provision of growth funding to rural and remote regions has principally focussed on the expansion of assessment and treatment services.

The provision of case management or skill development services can be affected by the inherent need for practitioners to travel considerable distances on a regular basis in order to provide these services. In one region, Flexible Accommodation Service funding was used to allow a person to be temporarily located close to the mental health team to receive intensive case management. Another approach is to work in collaboration with other providers, such as general practitioners, to provide locally based services.

Staff turnover in rural and remote regions can represent a barrier to the establishment of a consistent service culture, creates an ongoing orientation training requirement and can adversely affect continuity of case management. In addition, to counter the recruitment and retention issues, most rural and remote mental health services have adopted a generic worker model – where generic rather than specific workers are recruited. This means that there may be a limited range of professions within the team at any particular time. The experience to date shows that few occupational therapists have been recruited as generic workers.

In some communities, working with other sectors can be enhanced by informal links with other providers and a comprehensive understanding of the services available in the region. However, in some communities there is an absence of community services and people need to travel considerable distances without public transport to access services. The availability of community based services can be further affected by adverse circumstances such as drought or the wet season.

Given the reality of providing rehabilitation services in rural and remote areas, some practitioners commented that any rehabilitation assessment tool and process needs to be appropriate to the service context. An advantage of the COPM tool, recommended in the development of this policy, is that the goals are made collaboratively between the client and the worker. Consequently the goals can take into account the local environment and resources.

Flexibility in service models will continue to be required to ensure that appropriate services are provided in rural and remote areas of the state. One conclusion of the report *Community Support Services for People with a Mental Illness* (McDonald 2001) is that the range of community support services purchased by the Office of Mental Health could be adapted to suit the needs of the North West.

An example can be drawn from the model developed by the Kimberley Aged Care Service (KACS), whereby most elderly people living in remote Aboriginal and Torres Strait

Islander communities are able to receive support such as a meal and home help. A local person is employed and trained up to be the direct provider, with an infrastructure of coordination and support via a regional coordinator who has regular contact and community visits. An adaptation of this model would see the Disability Support Worker being the direct and local provider of 'psychiatric rehabilitation', with the case manager providing other clinical services and supervision. The infrastructure of coordination could come from positions attached to existing mental health services. This model would require significant consideration of the training and supervision needs of the disability workers and the provision of adequate resources to establish the infrastructure to provide the coordinating roles.

A further issue identified was the inequity of resource distribution that can result when there is a limited response to tenders for non-government services in rural and remote regions. This has been a particular issue for the provision of support and carer services. As indicated in *Supported Community Living for People with a Psychiatric Disability – A Home in the Community* (Office of Mental Health 2003), the Office of Mental Health is committed to maintaining flexible approaches in developing services in rural and remote areas in order to address this issue.

## 20.0 ISSUES FOR INDIGENOUS PEOPLE

Indigenous people have the poorest health, social and economic outcomes in the Australian population. Consequently, the focus of a rehabilitation policy will be too narrow to encompass and address the broader mental health, general health and social wellbeing of indigenous people. An all-of-local-community and all-of-government approach will be beneficial to all Australians with serious mental health concerns, and particularly indigenous people.

Previous mental health reform consultations have highlighted the importance of recognising “the diversity that exists within the indigenous community and promotes the importance of identity that determines a sense of belonging and ownership within kinship systems where indigenous people have power and control over their own destiny” (Metropolitan Mental Health Service 2001a).

Aboriginal and Torres Strait Islander people want “collaborative, culturally sensitive and flexible mental health care strategies that also address the mental health and wellbeing of the indigenous consumer’s family and their community where appropriate” (Metropolitan Mental Health Service 2001a).

Indigenous mental health “encompasses the cultural values, beliefs and protocols which include the physical, emotional, economic, spiritual, environmental and ecological dimensions that promote the mental health and wellbeing of indigenous people within an





holistic framework'' (Metropolitan Mental Health Service 2001a).

This policy gives consideration to an holistic life needs framework and the role of broader environmental, community and societal realities. However, further understanding and articulation of an indigenous holistic framework and associated service models is required.

Also, the relevance of the concept of the recovery journey for indigenous people needs to be examined and understood. There are indigenous programs outside the mental health sector that have been promoting social wellbeing for a number of years.

There are some directions already established from consultations and reports on indigenous people's health and social wellbeing needs that should not be ignored in developing a mental health rehabilitation approach for indigenous people within Western Australia. These include the:

- need to gain a cultural understanding of mental illness in indigenous communities;
- need for healing and recovery of mental and social wellbeing for indigenous people, recognising the serious impact of history and associated destruction of cultural wellbeing for indigenous communities;
- fact that indigenous people with serious mental health issues not only have to deal with the stigma associated with community attitudes to mental illness but also the extra burden of racism;
- requirement of indigenous health workers to undertake ongoing training and support to work in specialist and mainstream services;
- necessity of having specific culturally appropriate health promotion material and strategies for indigenous people; and
- considerable need for advocacy and education work with mainstream services and government agencies to achieve an improvement in the health and quality of life of indigenous people with mental illness.

A key issue, identified through discussions with indigenous representatives, was the need for culturally appropriate assessment of indigenous people. Such an assessment needs to take into account a range of issues pertinent to indigenous people such as grief and loss and cultural issues. Appropriate assessment was felt to be particularly important for young people and people whose diagnosis may be complicated by alcohol and drug issues. The assessment process is also an important issue given the level of distrust that is felt by some indigenous people toward the health and mental health system. In instances where community and family linkages are strong, mental health practitioners may need to respectfully offer their assessment advice to the community for consideration.

The University of Western Australia's epidemiology unit is currently working on an indigenous mental health project. It will develop a glossary of terms, concepts and

definitions about Aboriginal mental health, and from this develop a semi-structured interview schedule that is culturally appropriate and relevant to indigenous communities.

The importance of family and community has also been emphasised. A situation can arise where the person with a mental illness has a significant family and community role in caring for others. In addition, indigenous people with mental illness may be cared for by their family, their community, or may travel around to different families. This pattern of caring may continue for a substantial period and the person may only present to, or request the advice of, health services as a last resort. The building of trust between indigenous communities and mental health services is vital to ensure that early intervention can occur, rather than the community managing the person for an extended period and their mental health deteriorating. This is particularly important for young people whose lives and development can be enhanced through early intervention.

These caring responsibilities can place additional pressure on families and communities that are already socially and economically disadvantaged. In some instances, the families that are caring do not regard themselves as carers and are not accessing benefits such as carer assistance.

Given the importance of family and community, care plans need to be developed in conjunction with community and family members and build on existing strengths and resilience within communities. Family support services need to acknowledge the role of other family members (rather than just the immediate family members or the parents) and the role of elders and matriarchs within the community.

In relation to health and wellbeing programs, there is a need to recognise the poor health of many indigenous people and ensure that appropriate treatment is secured for these conditions. It is also important to ensure that educative information is provided in an appropriate language for the family or community needing the information.

Access to mainstream community services can be supported by people having a worker to help guide them through services and Aboriginal and Torres Strait Islander people working in agencies. Also helpful is the inclusion of Aboriginal and Torres Strait Islander art in building foyers and Aboriginal and Torres Strait Islander people in posters and advertising material. In addition, the inclusion of Aboriginal and Torres Strait Islander people in selection panels and other recruitment processes can ensure that people are selected who are appropriate and acceptable to the local communities they are being employed to work with.

The need for mental health training and education for both community members and non-indigenous workers was emphasised. Also, the work being carried out by other sections within the Department of Health and other government and non-government



agencies should be capitalised upon. This is particularly advantageous where a trainer or educator has experience and credibility with indigenous communities.

An overarching theme is the need to ensure collaborative efforts between departments and agencies are continued to appropriately and sensitively respond to the needs of indigenous people throughout Western Australia. These efforts need to acknowledge the existing strengths and resilience within communities and continue to build community capacity.

Further approaches to meet the needs of indigenous people include:

- working in cooperation with indigenous support groups; and
- employment of indigenous people within mental health services.

## **21.0 ISSUES FOR PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS**

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People from culturally and linguistically diverse backgrounds are those people who meet one or more of the following descriptions:

- those whose country of birth has a national language other than English;
- those who were born in Australia and have a least one parent born in a mainly non-English speaking country; or
- those whose predominant social orientation or identification is with a non-English speaking culture (Mental Health Division 2001).

The issues and strategies highlighted in *A Transculturally Oriented Mental Health Service for Western Australia* (Mental Health Division 2001) are important in the implementation of psychiatric rehabilitation services throughout Western Australia. These issues include:

- improving the cultural knowledge of mental health service practitioners;
- improving the availability of culturally appropriate forms of information about mental illness, mental health issues and services;
- improving consultation and liaison between general practitioners and mental health services to improve access to appropriate mental health service providers;
- accommodating the preference of some ethnic communities to use traditional networks of support such as traditional healers;
- ensuring the collection of relevant ethnicity data; and
- improving the understanding of issues related to high risk sub-groups within culturally and linguistically diverse communities.

While recognising that CALD populations are diverse, a number of issues were consistently raised through the policy feedback process. The providers of rehabilitation services to CALD people need to consider these issues:



- recognition of appropriate ways to provide services. For example, some independent living and assertiveness skills may not be relevant or culturally appropriate for people from some cultures;
- the need for culturally sensitive assessment tools and inventories;
- language barriers;
- family and carer support sensitivities – particularly a ‘culture-bound’ sense of responsibility to directly care for ill family members;
- CALD people’s potential discomfort with group activities;
- the small number of CALD people in rural and remote areas;
- cultural awareness and cultural competency across the health sector, including GPs;
- the CALD community’s perception of a person’s experience of mental illness; and
- CALD families and communities can potentially feel intimidated by health professionals.

The policy, *A Transculturally Oriented Mental Health Service for Western Australia* (Mental Health Division 2001), identified the following strategies for improving service operation:

- a mental health access service;
- consumer and carer participation;
- support of bilingual practitioners;
- effective use of bicultural mental health staff;
- culturally sensitive clinical assessment; and
- community support services.

A number of strategies have recently been progressed including the development of translation guidelines, provision of cross-cultural awareness training to clinicians, minimum data set and identification of culturally sensitive clinical assessment.

Other suggested approaches to meet the needs of CALD groups include:

- improved coordination of appropriate services that can be accessed by CALD people across regions;
- the establishment of linkages and partnerships between mental health services, in particular those between the treating clinician, welfare organisations and key ethnic people in the person’s community, to facilitate the best possible outcomes for their recovery;
- working in partnership with community settlement services (CSS) in rural and remote regions to facilitate the person’s recovery and acceptance of their illness by the community. CSS workers will have links with key community representatives who can greatly assist in the person’s reintegration to the community;

- practitioner initiated education of the person's family and community to debunk myths about illness behaviour, so as to reduce 'labelling' and alienation by the community;
- rehabilitation programs to assist people gain confidence to reintegrate into their community;
- rehabilitation activities which involve members of the persons community;
- an emphasis on in-home support for people from CALD backgrounds who may feel a strong sense of responsibility to their family members; and
- one to one practitioner discussion may be more beneficial for CALD people who find self-help groups inappropriate.

This policy recognises the work that is being done to meet the needs of CALD groups. A project to identify culturally appropriate mental health assessment tools is currently being undertaken by Edith Cowan University, ASeTTS and the West Australian Transcultural Mental Health Centre. The West Australian Transcultural Mental Health Centre, through its collaborative links and network and the Multicultural Forum of Mental Health Practitioners, have also taken initial steps in addressing the fragmentation of knowledge and coordination of services that can be accessed in the recovery process of CALD people with a mental illness.

## **22.0 ISSUES FOR CHILDREN AND ADOLESCENTS**

A number of issues specifically related to the provision of rehabilitation services for children and adolescents were raised through the policy feedback process. Overall, rehabilitation services for children and adolescents need to be differentiated from those for adults or older adults due to the significantly different developmental needs of children and adolescents. There also needs to be a strong emphasis on the involvement of family, carers and support networks.

Effective integration of rehabilitation services within the child and adolescent mental health services sector is sought. Specific rehabilitation services need to be provided through child and adolescent services. These services need to take account of the developmental requirements of children and adolescents and be staffed by personnel skilled in working with children and adolescents.

Statistics indicate that 27% of Child and Adolescent Mental Health Services (CAMHS) clients have learning disabilities and that children with poor educational attainment are at a significant risk for mental health difficulties (CAMHS Working Party 2003). As such, a multidisciplinary team approach to assessment and treatment of children and adolescents may be appropriate. Occupational therapists and speech pathologists could be included in the traditional team of psychiatry, nursing, clinical psychology and social work, in order to assess and advocate for

children who present with co-morbid developmental problems. These team members are important for correct differential diagnosis and to provide discipline assessments of language and sensory motor problems that may impact on children's mental health.

For children and adolescents with a mental illness the focus of rehabilitation is on early intervention and continuity of care. At the first point of contact strengths of the child or adolescent should be identified to reinforce resilience. Minimising hospital admissions is recognised as important and services such as the First Psychosis Liaison Unit at Bentley circumvent hospital admission of children and adolescents with mental illness through early identification of illness, prescribing low dose medication, and promoting the engagement of families and other networks. For children and adolescents who are at risk, or require a higher level of support, hospitalisation may be necessary. In this instance care, should be provided in a supportive environment with few restrictions and be in units "streamed by phases of illness and developmental stage" (McGorry & others 2003).

Children and adolescents have specific developmental needs from the age of 13 to 16, which may be disrupted by mental illness. A number of important social and living skills are learnt at this age. It is important that children and adolescents are reintegrated into mainstream activities and schooling during this crucial stage of development.

There are a number of services available to facilitate the formation and continuation of normal peer relationships including those provided by:

- occupational therapists;
- 'special schools' such as the Andrew Relph School, based at the Warwick Child and Adolescent Clinic (for 12 to 14 year old students with significant emotional, educational and peer relationship difficulties); and
- the Bentley Transition Unit (for youth recovering from an episode/exacerbation of mental illness who would struggle with immediate social and academic re-integration – social and living skills are explored in small groups and a staffed classroom is available).

Some children are identified with mental health difficulties at a younger age with social and peer relationship issues. This is addressed at both an outpatient level, through social skills groups, and also through the Families At Work program, where anger management and social skills groups are run by nursing, occupational therapy and speech pathology staff, as a part of the inpatient program.

The Department of Education and Training is currently in the fourth year of a state-wide mental health trial, which aims to keep students with a mental illness engaged in mainstream education. Government school

For children and adolescents with a mental illness the focus of rehabilitation is on early intervention and continuity of care



students are eligible for support from Education Assistants (EA) if they have a clinically diagnosed mental illness (excluding Attention Deficit Hyperactivity Disorder [ADHD]) which is impacting on their ability to access education at their local school. EA support applications are completed by the student's school, in consultation with the School Psychologist. The applications are then considered by a multidisciplinary committee, which allocates EA support based on demonstrated need, interventions already tried, level of other available support and geographical factors. The Department of Education and Training is currently undertaking a review of all services for students with mental health issues in WA government schools to improve coordination of services and interagency links.

For those aged from 15 to 18 years who would like to enter the workforce, there are a number of work readiness and assistance programs. These include Workright, Workability Employment Strategy and TAFE support. At this age it is important that bridging services, which interface with adult services, are also provided to maintain engagement with mental health services.

Supported accommodation options for adolescents with severe and chronic mental disorders are crucial. The population between 16 and 18 years require a particular focus as there are very limited specialist inpatient facilities and currently no supported community accommodation options for this age group. Comments received relating to housing stressed the need for:

- flexibility in housing;
- liaison services in Supported Accommodation Assistance Program(SAAP) Youth Accommodation Services;
- acceptance of individual needs; and
- development of protocols between housing providers and child and adolescent services.

A number of other child and adolescent issues were raised related to:

- assessment tools which are appropriate for use with children and adolescents; and
- co-morbidity and the range of services and agencies that need to be involved. There needs to be access to services, such as the approach taken with multisystemic therapy, which brings together various agencies. Alternatively Drug and Alcohol workers could act as consultants to mental health services.



# Glossary and Abbreviations



**ACT** – Assertive Community Treatment

**Activity Limitation** – difficulties a person may have in executing activities.

**ADAPT** – Alcohol, Drugs and Psychiatric Treatment

**ADL** – Activities of Daily Life

**ASeTTS** – Association for Services to Torture and Trauma Survivors

**CALD** – Culturally and Linguistically Diverse

**Carer** – a person, such as a friend or relative, who has a caring role with a person with psychiatric disability. In this policy the term carer does not include people who are employed to provide care for a person with psychiatric disability, such as people employed through government and non-government agencies.

**CAMHS** – Child and Adolescent Mental Health Services

**Case Management** – a means of coordinating services for people with a mental illness. Case managers assess people's needs, develop care plans, arrange care, monitor care quality and stay in contact with the person (Holloway 1991 in Marshall & others 1997)

**COPM** – Canadian Occupational Performance Measure

**CSS** – Community Settlement Services

**ECU** – Edith Cowen University

**EPPIC** – Early Psychosis Prevention and Intervention Centre

**Impairment** – problems in body function or structure such as a significant deviation or loss.

**Mental Illness** – a diagnosable illness that significantly interferes with a person's cognitive, emotional or social abilities. There are different types and varying degrees of severity of mental illness, including depression, anxiety, substance abuse, bipolar disorder and schizophrenia.

**Mental Health Services** – specialised health services for the treatment and support of people with mental disorders.

**Participation Restriction** – problems a person may experience in involvement in life situations.

**Prevocational Training** – an approach in which participants undergo a period of preparation before seeking competitive employment. This could involve either work in a sheltered environment or Clubhouse, or some form of pre-employment training or transitional employment. In Western Australia this is also called supported employment.

**Psychiatric Rehabilitation** – this policy document adopts the term psychiatric rehabilitation and defines it as the formal principles and active specialised strategies within a comprehensive mental health service system, and external to the system, that supports people with a mental illness to address difficulties in their life roles and participation restriction in society. Psychiatric rehabilitation includes:

- enhancing and supporting the person's journey towards recovery and well-being;
- identification of the person's needs and life goals;
- providing relationship and environmental supports;
- assisting the development of skills critical for effective life management;
- increasing a person's capacity for independence and interdependence;
- successful access to community resources and opportunities; and
- participation in community life without the experience of discrimination and prejudice.

### **Recovery/Recovery Journey**

“Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributive life even with limitations caused by the impairment. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of an impairment” (Anthony 1993).

**Residential Rehabilitation or Facility Based Accommodation** – facilities where people live for a period of time, with an emphasis on rehabilitation services during their stay. This can be in specific facility based rehabilitation or in conjunction with treatment services such in step-down or intermediate care facilities.

**Specialised Clinical Interventions** – services requiring practitioners with clinical expertise, for example cognitive behavioural therapy, psychotherapy or rehabilitation programs directed to people with a particular mental illness.

**Supported Employment** – any approach to vocational rehabilitation that attempts to place clients immediately in competitive employment. This may include a preparation period of less than one month. In Western Australia this is called open employment.

**SAAP** – Supported Accommodation Assistance Program services funded by the Commonwealth and Department for Community Development (DCD).

**Treatment Services** - treatment services can be distinguished as those services that focus principally on the reduction in impairment – that is the reduction in disorder in thoughts, feelings and behaviour. Treatment services include provision and monitoring of medication, crisis and emergency services.

**WAAMH** – Western Australian Association for Mental Health

**WHO** – World Health Organisation

**WRAP** – Wellness Recovery Action Plan



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# Appendix One

## DEFINITION OF SERIOUS AND PERSISTENT MENTAL ILLNESS

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In order to be assessed as having a mental illness that is serious and persistent, the following conditions need to apply:

- The presence of one of the following diagnoses:
  - Chronic or recurrent psychosis (such as schizophrenia, bi-polar affective disorders).
  - Organic brain disorder associated with significant psychiatric features (such as some chronic sequelae associated with brain injury and some medical conditions e.g. Huntington's Disease).
  - Chronic non-psychotic disorders that may result in functional impairment<sup>3</sup> (such as Obsessive Compulsive Disorder {usually there is only a minority with this level of impairment}, personality disorders which result in functional impairment, self injury, significant behavioural problems).
- Severe and chronic activities of daily life impairment<sup>4</sup>.

In essence, to confirm the seriousness and persistence, a person must demonstrate:

- a level of functional impairment that is associated with having a diagnosed mental illness that interferes with the person's ability to live independently to the extent that they:
  - require support with the activities of daily life; and/or
  - support is not available and the essential activity does not occur;
- and
- their level of impairment is long term and not the result of a short term acute episode.

The function of the diagnosis, as it relates to determining 'serious and persistent', is to determine the type, duration and severity of the impairment and the existence of risk factors which may exacerbate the person's condition. Such risk factors include:

- existence of co-morbidity (intellectual, physical and/or substance abuse).
- lack of effective environmental support.
- lack of functional social networks (social isolation).
- unstable accommodation.

An evidenced based assessment to confirm 'serious and persistent' requires a multi axial diagnosis classification. This includes assessment to determine:

- psychiatric diagnosis;
- intellectual capacity;
- medical status; and
- evidence of psycho-social risk factors that are highly correlated with severe daily functional impairment.

As well, the person's impairment must have been in existence for over six months. During the past two years the person is likely to have had one or more admissions to an acute facility, particularly if there is inadequate support given their level of functional impairment.

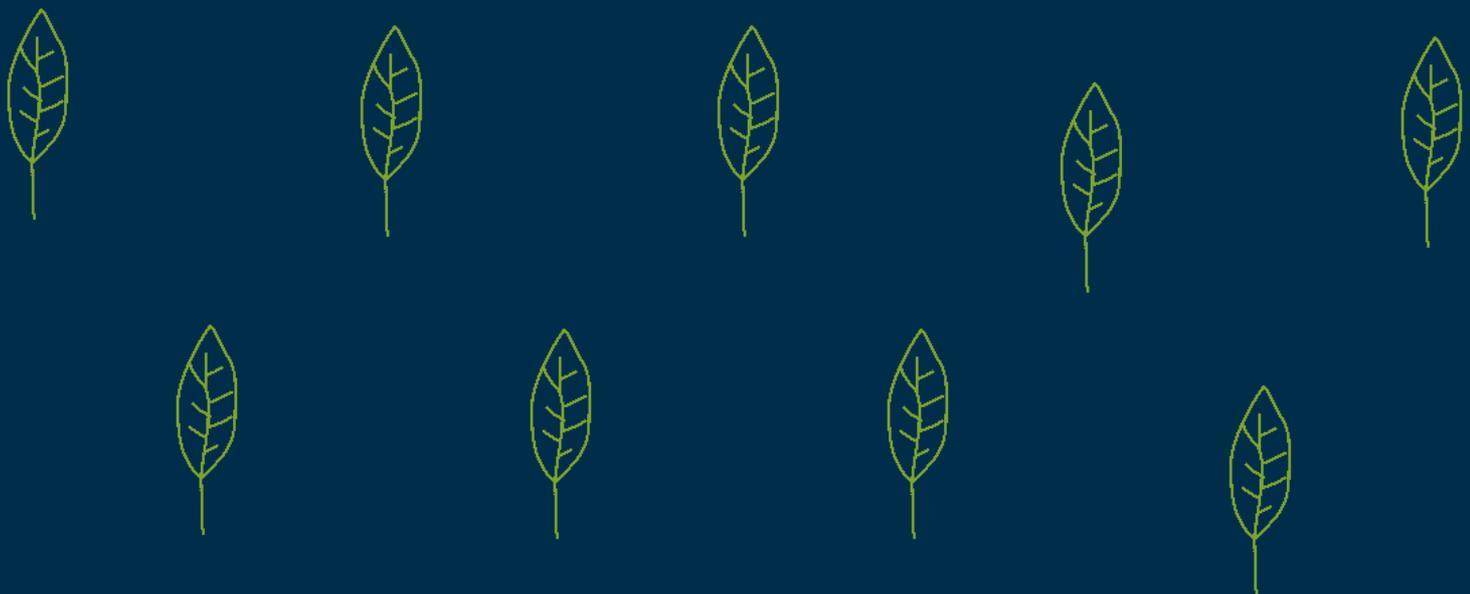
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<sup>3</sup> Functional impairment refers to a person's inability to undertake successfully the activities associated with daily life and general life independence. This impairment is likely to severely restrict their quality of life and their ability to achieve their life goals and needs.

<sup>4</sup> Activities of Daily Life include activities in areas such as personal hygiene and grooming, home management, financial management, general health, communication, community access for home maintenance (for example shopping, bill paying) and recreational purposes, socialising and so on (this is not a definitive list of areas).







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