

Victoria's Mental Health Services

**Psychiatric Disability Rehabilitation and
Support Services**

Guidelines for Service Delivery

February 2003

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1. INTRODUCTION

1.1 Background

Victoria has a strong tradition in the provision of psychosocial rehabilitation and disability support programs in the community sector and has established a lead role amongst Australian States and Territories.

In 1992, the term ‘psychiatric disability support service’ was adopted by a range of community-based services providing support and rehabilitation to people with a mental illness. It symbolised the maturing of the sector and recognition of its particular contribution to supporting people with a mental illness in the community.

In 1994, the document *Victoria’s Mental Health Service, the Framework for Service Delivery* recognised these services as a core component of a comprehensive and integrated network of services, working collaboratively in the best interests of the service user. Importantly, it also recognised that mental health policy needed to address the impact of mental illness on a person’s activities of daily living and the social disadvantage resulting from the illness itself.

Since 1992 the psychiatric disability services sector has significantly grown and diversified. In 2002 it provides support and rehabilitation to over 9,000 people, with another 11,000 accessing mutual support and self help services – in 1992 it was just over 2000.

In 2002, Psychiatric Services of Victoria (VICSERV) the peak body for community based psychosocial rehabilitation programs consulted with its sector and gained widespread support for a name change, one that recognized its rehabilitation role. Services are now known as Psychiatric Disability Rehabilitation and Support Services (PDRSS).

These services provide specialist services and programs for people with a psychiatric disability. They aim to create opportunities for both recovery and empowerment. They have a commitment to the following principles:

- Provision of individualised, high quality programs of psychosocial rehabilitation and support for people with psychiatric disabilities.
- Accessibility to participants and potential participants.
- Responsiveness to the needs of participants.
- Responsiveness to the needs of their local service area.
- Encouragement and support for the involvement of participants and carers where appropriate, in service planning, implementation, evaluation and management.
- Promotion of community acceptance and the reduction of stigma for people affected by mental illness.

1.2 PDRSS and the Service System

Victorian public mental health service system comprises clinical and psychiatric disability rehabilitation services:

- Clinical mental health services are managed by public hospitals and provide assessment, diagnosis, treatment, rehabilitation and clinical case management services to people with a serious mental illness; and include both residential and non residential components. Clinical care treatment includes the provision and monitoring of medication.
- PDRS services have a different focus to, and are designed to complement, the clinical services in the mental health system. They provide psychosocial assessment, rehabilitation and support, and are managed by non-government organisations in the community.

PDRS services also differ from general community support services through the expertise necessary for understanding and working with the effects of mental illness. This specifically involves enhancing self-esteem, social and living skills and the quality of life of participants that have been eroded by the presence of mental illness and associated psychiatric disabilities. Psychiatric disability support programs also provide a foundation from which participants gain access to general community services and make more effective use of these services.

1.3 Guidelines for PDRSS

These guidelines aim to provide a detailed understanding of the policy guiding the provision of Psychiatric Disability Rehabilitation and Support Services and service requirements. They also aim to stimulate further discussion and debate about the best way to provide rehabilitation and disability support services into the future.

2. POLICY AND LEGISLATIVE CONTEXT

2.1 Victorian Mental Health Policy

The document *Victoria's Mental Health Services, the Framework for Service Delivery (1994)* provided a detailed framework for the development of a comprehensive network of mental health services to replace institutional care. The framework guided service development over a five-year timeframe, allowing for the redevelopment and redistribution of services to take place in a uniform and consistent manner.

Having achieved the majority of structural reforms set out in the *1994 Framework*, mental health policy development is now focusing on the strengthening and expanding of mental health services to provide a more accessible and responsive mental health service system. The '*New Directions for Mental Health Services*' document outlines the guiding principles and key directions for services for the five years 2002 – 2007.

The guiding principles are:

- Priority to those in greatest need
- Care in the community whenever possible
- Consumer and carer participation
- Service quality and responsiveness
- Continuity of care.

The six key directions are identified as:

- Expanding service capacity
- Creating new service options
- Extending prevention and early intervention
- Building a strong and skilled workforce
- Strengthening consumer participation
- Improving carer participation and support.

Psychiatric disability rehabilitation and support services will continue to have as their primary target group people with serious mental illness and related psychiatric disability. Services can expect to continue to play a significant role in assisting people to live successfully in the community, including a focus on preventing relapse and providing options for people following an inpatient admission. Programs that assist people to access and maintain accommodation will be particularly important. There will also be opportunities for PDRSS to look at different ways of delivering services, particularly in closer partnership with their clinical service counterparts, as new service options are developed.

PDRSS will also be required to participate in a range of activities designed to promote continuous quality improvement and support quality service provision.

2.2 National Mental Health Policy

Victoria's mental health policy is predicated upon a commitment to the implementation of the National Mental Health Policy. The National Mental Health Policy is a joint statement by the Health Ministers of the Commonwealth, States and Territories of Australia that aims to ensure that appropriate services are readily accessible to all Australians with mental health problems or mental disorders.

The First National Mental Health Plan in 1992 advocated structural reform, priority allocation of resources to people with severe mental health problems, the importance of consumer and carer participation, improved accountability, better cross sector linkages and an increased focus on mental health promotion.

The Second National Mental Plan in 1998 extended the work undertaken through the First National Mental Health Plan. It promotes services that can improve treatment and care for a broader range of people with high level needs whilst continuing service reform to existing clients. The plan focuses on three priority areas for future development to achieve this aim. These priority areas are:

- **Promotion and Prevention**

The Plan identifies psychiatric disability rehabilitation and support services and other non-government organisations as key settings for *mental health promotion* and *community education*. Psychiatric disability rehabilitation and support services are also recognised as playing a vital role in prevention and early intervention in relation to the development of associated psychiatric disabilities.

- **Partnerships in Service Reform and Delivery**

Partnership arrangements are encouraged at both system and service levels through policies, procedures, protocols and funding. Key strategic alliances include those between Psychiatric Disability Rehabilitation and Support Services and participants, families and carers, clinical public mental health services, general practitioners, private psychiatrists, the general community and other health and community support services. Particular attention is paid to the difficulties that people with psychiatric disabilities have in obtaining access to general disability support services (including recreation services and those funded by the Commonwealth under the Commonwealth State and Territory Disability Agreement), housing, income support, employment and home and community care.

- **Quality and Effectiveness**

The Plan encourages mental health services to use standards, benchmarks and models of best practice to achieve improved participant outcomes and ensure continuous *quality* improvement and increased *effectiveness*. Attention to education and training, and the development and refinement of measures of effectiveness, are all essential for the achievement of these objectives.

2.3 The Legislative Context

Psychiatric disability rehabilitation and support service delivery in Victoria is governed by three major pieces of State and Commonwealth legislation:

- *Mental Health Act (1986) (Vic)*
- *Disability Services Act (1986) (Cth)*
- *Disability Services Act, (1991) (Vic)*

Mental Health Act (1986)

The *Mental Health Act 1986* specifies the principles that govern the operation of mental health services:

- People receive the best possible care and treatment appropriate to their needs in the least restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment.
- Provision is made for persons who are receiving the service to participate in the planning, operation and evaluation of the service.
- Restrictions on and interference with the rights, privacy, dignity and self-respect of persons receiving the service is kept to the minimum necessary in the circumstances.
- There are adequate mechanisms for the assessment and review of persons receiving the services.
- The service provided is accessible and flexible in order to meet the needs of people with a mental disorder.

The *Mental Health Act 1986* also stipulates the conditions regarding client confidentiality. Any disclosure of confidential information about a participant outside the provisions of the *Mental Health Act* requires the participant's informed consent. If the participant refuses consent, section 120A(3)(ca) of the *Mental Health Act* enables disclosure to others of information reasonably required for the on-going care of the participant.

Commonwealth Disability Services Act (1986)

Psychiatric disability rehabilitation and support services are purchased in the context of the *Commonwealth State Territory Disability Agreement (CSTDA)*. Under the CSTDA, services must abide by the Principles and Objectives of the *Commonwealth Disability Services Act 1986* and the National Disability Services Standards.

The *Disability Services Act (1986)* aims to facilitate community integration and participation of people with disabilities by providing the legislative base for the delivery of accommodation, employment, social and living skills support, research and advocacy services.

Amendments to the *Commonwealth Disability Services Act* in 1992 introduced standards for services that act as a benchmark of quality. They require that services:

- Have written policies and procedures on mechanisms to maximise participant participation in decisions made by the service and to make these policies and procedures available to participants in appropriate formats.
- Offer support to each person with a disability, to make informed decisions and choices about the services he or she receives.
- Inform each participant of other services that might meet his or her needs.
- Involve participants in developing and reviewing service policies.
- Enable participants to be involved in making decisions about the services they receive.
- Not restrict the right of each person with a disability to exercise control over his or her life.

Victorian Disability Services Act (1991)

Victoria's *Disability Services Act (1991)* sets out the principles to be pursued with respect to people with disabilities as well as the objectives for service providers and researchers. It also makes provision for the funding of disability services. Services funded by the State under the CSDA are subject to the terms of the *Commonwealth Disability Services Act (1986)* and the *Victorian Disability Services Act (1991)*.

2.4 Other Important Acts

There is a range of other Acts that services should ensure they comply with and/or need to be aware of as service deliverers to assist their clients. These include:

Health Records Act and *Privacy Act* – these Acts set out the rules regarding the handling of client records. The *Mental Health Act* has been amended for consistency with these Acts.

Disability Discrimination Act and *Equal Opportunity Act* – these Acts disallow discrimination on the basis of disability against a person with a disability or a person associated with a person with disability. They can be important tools in advocating for the rights of clients and assisting service users to understand and advocate for themselves.

Residential Tenancy Act – Many mental health services will be providing support to people renting either in the private or public sector. The *Residential Tenancy Act* also covers people in property provided through Transitional Housing Management and Community Housing providers.

2.5 National Standards for Psychiatric Disability Rehabilitation and Support Services

The Australian Health Ministers' Advisory Council (AHMAC) Working Group on Mental Health endorsed *National Standards for Mental Health Services* in December 1996. The standards apply to all mental health services throughout Australia.

The National Standards for Mental Health Services have been adapted into a separate policy document to articulate the principles that specifically govern the delivery of Psychiatric Disability Rehabilitation and Support Services. Called “Standards for Psychiatric Disability Rehabilitation and Support Services’, they reflect the specialist rehabilitation and support focus of these services, provide a comprehensive set of standards to enhance service quality and improvement, and establish best practice models of service delivery.

During 2002–2003, a process will be developed to enable services to seek accreditation against these Standards.

3. TARGET GROUP & ELIGIBILITY

The target group for most PDRSS is people with a psychiatric disability as a result of a serious mental illness. Some services (mutual support and self help {MSSH} and planned respite) also have carers or family members as their target group.

Different PDRSS types may also have additional eligibility criteria that relate to the service being offered. For example, people accessing a linked housing and support program, will need to be eligible for public housing. From time to time, specialist programs may also be developed to respond to a specific need, such as to young people or to those who are homeless. Specific service guidelines that clarify the target group are developed for these programs.

In determining eligibility for PDRSS (excluding MSSH), the following should be taken into account:

- Clients receiving case management services from the public mental health service and referred by the service are automatically eligible for support from the PDRSS.
- All clients should have a mental illness or disorder as defined by the Mental Health Act that is associated with a significant psychiatric disability. Where the client is not referred by a practitioner who has confirmed that the person has a mental illness (eg private psychiatrist, public mental health service), the service should seek confirmation of the diagnosis from a clinical service provider. This must be done with agreement from the client.
- Clients should live in the mental health service area where the service is located. In recognition that clients:
 - move out of an area but may wish to remain in their existing service
 - may want to access a service where their carer lives
 - are unable to access their local service for another reason,

five percent of clients may be from out of the catchment area. Services should give priority to clients from within their own catchment area.

- Unless otherwise agreed with the Department of Human Services, new clients should be aged between 16 – 64 years. However, services should continue to support clients who turn 65 years of age while the service is still appropriate and able to meet their needs.

In determining priority for access to PDRSS (excluding MSSH), the following should be taken into account:

- Priority should be given to those with the highest levels of disability – this is regardless of diagnosis or capacity for rehabilitation/change.
- Only where there is more than one eligible person with similar levels of disability and need, should priority be given on the basis of length of time someone has been waiting for a service.

4. PROVISION OF PSYCHIATRIC DISABILITY REHABILITATION AND SUPPORT

4.1 Psychosocial Rehabilitation

The provision of psychosocial rehabilitation is a key component of a PDRSS. The *Standards for Psychiatric Disability Rehabilitation and Support Services* define psychosocial rehabilitation as:

...the provision of ongoing support that assists the person with a psychiatric disability to experience an improved quality of life, learn or relearn the skills of daily living, participate to the maximum extent in social, recreational, educational and vocational activities and live successfully at an optimal level of independent functioning in the community.

Psychosocial rehabilitation is informed by belief in the potential of every individual to change and grow, and focuses on the individual's strengths and abilities rather than their illness. The assessment of those skills and abilities and the majority of the work undertaken on relearning old skills and developing new ones occur in the settings of everyday life, ie. the individual's home or community.

The delivery of psychosocial rehabilitation is through a range of individual and/or group activities that respond to the needs and goals of individual participants. Activities may focus on:

- Skill development, such as learning or relearning the skills required for activities of everyday life
- Peer support
- Exploration of the self and illness through creative pursuits.

The principles of psychosocial rehabilitation were originally articulated by Cnaan in the *Psychosocial Rehabilitation Journal* (1988). These principles were adapted by the Victorian community managed sector in 1992 and are listed in Appendix A.

The series '*Psychosocial Rehabilitation: Working With People with a Psychiatric Disability*', available through VICSERV, provides practical guidance on delivering psychosocial rehabilitation programs.

4.2 The Key Worker

All participants in structured day programs, residential rehabilitation, supported accommodation and home-based outreach support should be allocated a key worker on entry into the service. The key worker is the person with whom the participant has primary contact within the service.

The key worker is responsible for:

- Collaborating with the participant in the development of an Individual Program Plan (IPP) that reflects the participant's disability rehabilitation and support needs.

- Coordinating the implementation of the participant's IPP.
- Developing, with the informed consent of the participant, a cooperative relationship with any carers involved with the participant.
- Ensuring that the participant receives the services and supports necessary to regain the skills and confidence required in activities of daily living and for the development and maintenance of social relationships.
- Facilitating the participant's access to, and participation in, a range of general community support programs and activities, including those provided by generic organisations. These include programs and activities relating to accommodation, education and training, income security, employment, recreation and leisure.
- On the request of the participant, acting as an advocate for the participant, especially in dealing with discriminatory attitudes and behaviour and in facilitating access to services.
- Facilitating contact and developing a cooperative relationship with clinical mental health services, particularly with a participant's case manager, private psychiatrist or general practitioner.

For more information on key worker skills refer to volumes 3 & 4 of the VICSERV practice guides series "*Psychosocial Rehabilitation: Working with People with a Psychiatric Disability*".

4.3 Assessment and Individual Program Plans

All participants of structured programs (day, home-based outreach support, supported accommodation and residential rehabilitation) are expected to have a psychosocial assessment from which an Individual Program Plan (IPP) is developed. The aim of the IPP is to facilitate the process of recovery and to assist participants to regain their place as an involved member of the community.

Who should be involved

The assessment of each participant's *rehabilitation and support needs* and development of the IPP are undertaken collaboratively by participants and their key worker.

With the consent of the participant, family members or others involved in a care giving role should be encouraged to be involved in the development of an IPP.

Where the participant is also a client of the public mental health service, the development of the IPP should be coordinated with the participant's clinical Individual Service Plan. This promotes consistency in practice and ensures that all parties are working together to achieve the same goals. The participant should have his or her own copy of the assessment and the IPP.

What should be in an IPP

A comprehensive psychiatric disability rehabilitation and support IPP should contain:

- A description of the participant's current situation.
- The participant's goals and the supports needed.

- Detailed strategies for achieving those goals. In relation to long-term goals, phases for achievement of those goals should be factored in to the IPP.
- Indicators for assessing when and whether those goals have been achieved.
- A timetable for review of the IPP.

While the scope of the IPP is an individual decision, the key worker should ensure a range of areas are explored in the assessment including understanding of the illness, coping strategies, daily living skills, self care, relationships, social skills, accommodation needs, and educational, vocational and recreation goals.

It should be written in clear, unambiguous, accessible language.

The timeframe for developing an IPP

The period of time needed to develop an IPP will vary, depending on the participant's level of trust. However, services should aim to have an IPP in place within two months of the service commencing.

A less formal approach to developing an IPP may be necessary for those participants who may find it difficult to engage with a service; for example those who have experienced significant transience and homelessness, or who state that they do not want to be involved in the development of an IPP.

Whether or not a formal written IPP is developed, the process of engagement and exploration of a participant's goals, aspirations and needs is an integral part of involvement in structured psychiatric disability rehabilitation and support services.

IPP Reviews

The IPP should be reviewed at regular intervals (at least six-monthly) by the key worker and the participant, and other appropriate people such as family and the case manager. Either participants or their key worker may initiate reviews of the IPP at other times.

4.4 Partnerships

PDRSS are important players in an integrated and comprehensive area mental health service system, as well as the mainstream community and primary care service system. PDRSS are expected to be responsive to the needs of their catchment area as well as the needs of individual participants. For many PDRSS, the local Primary Care Partnership will be an important network within which to promote the needs of service users in their local areas.

Strong linkages need to be developed with the range of generic and specialist services available in the community to facilitate access to these services for PDRSS participants and/or to ensure coordinated service delivery. Such services may include specialist mental health, health, housing, recreation, education and training, labour market, Home & Community Care (HACC), community recreation programs and neighbourhood house programs.

Linkages may take the form of:

- Development of appropriate interservice agreements about consultation and liaison mechanisms for shared clients.
- Development of referral mechanisms and protocols.
- Joint planning for the development and/or delivery of programs to more appropriately meet the needs of people with a psychiatric disability.
- Provision of support to participants involved in other services.

- Provision of advice and support to staff of other services about mental health issues.
- Effective partnership projects to assist people with psychiatric disabilities to exercise choice and control in their lives and increase their capacity to participate in community life.

4.4.1 Adult Mental Health Services

A key partnership will be with the local adult mental health service. Over 70% of PDRSS participants also receive case management services from the adult mental health service. Hence staff of both types of services are expected to work collaboratively, need to be aware of what each has to offer participants, how best to make referrals and provide consultation as required.

Psychiatric Disability Rehabilitation and Support Services and clinical mental health services in each mental health area are expected to:

- Develop policies and procedures that enhance access by participants to each type of service.
- Work collaboratively with mutual clients to enhance outcomes through collaborative work practices, including to support discharge from inpatient and residential programs.
- Develop and regularly review joint service agreements, including those between services provided at a regional or statewide level and those delivered locally.
- Develop and deliver innovative partnership programs, where appropriate, which pool resources and expertise and result in more effective outcomes.
- Participate in area-based, regional and statewide forums that enhance contact, provide information exchange and share ideas about improving service quality and area service planning.

4.4.2 Housing Services

Access to safe and affordable accommodation is recognized as important for maintaining mental health and well being. PDRSS are required to actively seek and promote partnerships with housing services, in order to assist their clients access housing and to maintain their tenancies. With the client's consent it can be valuable to develop a partnership arrangement with landlords – including the Office of Housing – so that the support provider can be contacted should there be a situation in which the tenancy is at risk.

Many PDRSS have nomination rights to properties in which they are able to provide support to the tenant. This means the PDRSS chooses the tenant for the property, ensuring a good match between tenant and property and prioritizing access to those most in need.

The Housing and Support Program has previously provided housing linked to home based outreach support. Clients needing to access this type of Program now need to apply through the supported housing segmented waiting list. This means that HBOS providers have an important role in facilitating clients to access priority-supported public housing.

4.4.3 Homelessness Services

PDRSS play an important role in preventing and addressing homelessness. Amongst Psychiatric Disability Rehabilitation and Support Services there are examples of services, which due to their geographic location or history, cater predominately for people who are

homeless. Many of these are also jointly funded by the Mental Health Branch and the Supported Accommodation and Assistance Program (SAAP).

Supported Accommodation and Assistance Program

The SAAP sector has a broad target group that includes people with a mental illness. However, it does not always have the skills or resources to provide an effective response to those who have more complex needs. In addition, the SAAP sector is designed to provide a crisis and transitional response. PDRSS therefore have an important role in providing pathways for people out of SAAP services as well as supporting SAAP services to provide a safety net response to people with a mental illness who do fall through the gaps.

While PDRSS funded as part of the Mental Health Homelessness Program are required to have a formal relationship with the local SAAP providers that include providing secondary consultation and joint assessment of clients for the service, all PDRSS should have effective links with the SAAP services.

Transitional Housing

Through the Victorian Homelessness Strategy, transitional housing stock has been specifically linked to PDRSS home based outreach support. However, people with a mental illness who are homeless may enter the Transitional Housing Management Program through normal means, with the PDRSS providing the support.

Transitional housing provides three-month tenancies in partly furnished properties. In partnership with the support provider, the THM will assist the client to access long term housing options, including applying for public housing.

THMs also have flexible funding, called Housing Establishment Funding, to assist people in times of crisis to ensure that tenancies do not fail and a Housing Information Referral service which provides advice and assistance regarding housing options.

4.4.4 Employment Services

Under the Commonwealth State Territory Disability Agreement, the Commonwealth has responsibility for the provision and funding of employment services. While PDRSS are not responsible for providing employment outcomes, need to develop appropriate prevocational programs and activities for participants with employment aspirations.

PDRSS also need to develop partnerships with a range of vocational rehabilitation, training and employment placement services such as the Personal Support Program, Commonwealth Rehabilitation Service and Specialist and Generalist Employment Programs, Jobnet Providers and a range of Vocational Training Providers. Through the creation of such partnerships, PDRSS can facilitate effective transition strategies for participants seeking employment opportunities.

4.5 Consumer Participation

Consumer participation includes consumers participating in their own care and treatment, as well as providing consumers with an opportunity to contribute to the systemic operations of the service. The former is promoted through individual program plans, while the latter

includes such things as paid consumer consultant positions, and involvement in service development, evaluation and management activities.

DHS expects services to continue to develop best practice in this area.

4.6 Carer Participation

Many family members and other carers have an ongoing role, and are important partners, in supporting people to live in the community. While many PDRSS do not provide direct services to carers, there is an expectation that PDRSS will respond to carers' needs through providing assistance to locate relevant services and information. Many PDRSS respond to carers' needs through hosting information sessions or providing access to the premises for carer support groups.

Where appropriate, and where the participant agrees, the carer should also be involved in the development of the individual program plan. Services should also involve carers in service development, evaluation and management activities.

4.7 Increasing community awareness

Psychiatric Disability Rehabilitation and Support Services must engage in activities that raise the level of community understanding and acceptance of people with psychiatric disabilities. This systemic developmental and educative work is particularly crucial at the time new services and programs are being established, but is also a key component of the ongoing work of PDRSS.

4.8 Training, Development and Research

Psychiatric Disability Rehabilitation and Support Services must demonstrate a commitment to the training and development of new and existing workers, managers and members of committees of management. They should also demonstrate a commitment to the development of the psychiatric disability rehabilitation and support sector as a whole by their involvement in the collective dissemination of information and development of PDRSS sector skills.

Services should be involved in the development of policy and program initiatives relevant to PDRSS delivery. In addition services should undertake or participate in research and evaluation projects of relevance to the PDRSS sector and to participate in specialist PDRSS interest groups.

The development and dissemination of material describing good practice, research results, evaluations, innovative service developments and other areas of interest to Psychiatric Disability Rehabilitation and Support Services, participants, carers, service purchasers and policy developers, should be a common activity.

VICSERV is the peak body in Victoria for Psychiatric Disability Rehabilitation and Support Services and is funded to provide training and professional development, information and policy development.

4.9 Service Planning

The responsiveness of services to the needs of their local service area is enhanced when services identify the demographic profile of their catchment area as well as the support needs of particular groups of people within the community, including women, people from culturally and linguistically diverse backgrounds, Koori people, parents with dependent children, and older and younger people with psychiatric disabilities.

4.10 Data Collection

All PDRSS are expected to provide quarterly data collections. The data collection is known as the Commonwealth State Territory Disability Agreement Quarterly Data Collection (CSTDA QDC). The collection includes data for Commonwealth Government reporting purposes and for the Mental Health Branch.

The data is used for:

- Monitoring service performance. All performance measures in the Service Agreement with the Department can be reported through the QDC.
- Planning. The data provides detail about the level of service activity and client characteristics that assists in understanding client needs, monitoring changes in the client population and service delivery issues. When linked to other data sources such as population data, service gaps and needs are better understood.
- Justifying expenditure. The Department is required to report to Government on expenditure of funding. The data collection enables the Mental Health Branch to report to Government that it is fulfilling its commitments.

The Department provides adhoc statewide reports on the data it receives from services. PDRSS should use and analyse their own data to identify trends and address issues.

4.11 Quality Improvement

PDRSS are expected to demonstrate a commitment to the principles of Continuous Quality Improvement. Continuous Quality Improvement implies a commitment to reflective practice, good processes and the ability to implement change. Commencing in 2002, PDRSS will be expected to participate in a number of activities designed to support the implementation of CQI practices. These are:

- The measurement of consumer and carer experience
- Outcome measurement
- Accreditation against the Standards for PDRSS.

5. DESCRIPTION OF PROGRAM TYPES

In Victoria, psychiatric disability rehabilitation and support services provide the following activities:

- *Psychosocial Rehabilitation Day Programs,*
- *Home-based Outreach Support,*
- *Residential Rehabilitation,*
- *Supported Accommodation,*
- *Carer Support,*
- *Planned Respite Services and*
- *Mutual Support and Self Help Services.*

The different service types enable people to access programs in different environments and offer different experiences, allowing people to participate in the program which best suits their needs. Increasingly, services are experimenting with different models with the aim of providing a flexible and individual response to people's needs.

Key service requirements are at Appendix C. Additional key service requirements for specialist programs may also exist. These will be listed in the service guidelines.

Key performance measures and reporting requirements for program types are reviewed and published each year as part of the Metropolitan Health and Aged Care Divisional Plan. The information is available at www.dhs.vic.gov.au/metro.

5.1 Psychosocial Rehabilitation Day Programs

Aim

Day programs aim to create a sense of belonging to a community, provide peer support and an atmosphere where a range of social and daily living skills can be learnt. A participant's involvement in a day program can also be an important source of support and respite for families and others carers. Day programs can be structured or informal drop in services.

Target Group

People with a psychiatric disability as a result of severe mental illness.

Program Operation

Location

Most day programs are provided in a specific purpose centre-based environment. A proportion of the service activity should take place in local community facilities or be delivered by the day program in partnership with other community services. This can include neighbourhood houses, coffee shops, gyms and church halls. This promotes community integration and ensures learning occurs in everyday environments.

In some rural areas, a service may operate a day program in a number of different locations, providing a service in one area some days of the week and in another area on the other days.

Opening Hours

Day programs are expected to provide a service to participants five days a week and 52 weeks a year. Some programs also offer activities in the early evening or on weekends. The hours of operation should reflect the needs of participants, but it is expected that services are available approximately 30 hours a week.

Service description

Psychiatric disability day programs provide a mix of structured and semi-structured psychosocial rehabilitation. The degree of structure and the mix of service elements vary according to the need identified by the service and its participants. A mix of services allows participants to engage with different program activities at different times, as their needs change.

Day program activities address the specific needs of participants through targeted group programs based on individual program plans or by consensus of groups of participants with similar needs or interests. They also provide the added value of participant 'involvement' in the service and peer support and understanding.

Service components

Structured Day Programs

Structured Day Programs aim to increase the social and living skills of participants through a variety of structured group activities in a safe, peer support environment where participants are accepted at their own level of functioning ability.

Programs vary according to the needs of the participants and can include pre-vocational preparation, stress management, recreation, art, cooking, educational, computers, health and fitness. Programs involved in *pre-vocational and employment preparation* activities assist participants wishing to enter or re-enter the paid workforce. Day programs may deliver pre-vocational programs themselves, including clerical, computer, gardening, cleaning, retailing and hospitality related skill development. Participants may also receive assistance in writing job applications, and in presentation and interview skills. Alternatively, participants may be supported to access pre-vocational activities provided by other services, eg the local Disability Employment Service, Commonwealth labour market programs, TAFE or Neighbourhood House, or activities run by the service in conjunction with those other services.

As well as developing specific skills, participants are encouraged to explore aspects of themselves through participation in a range of creative pursuits, eg music, drama and writing groups, and art and craft activities.

Participants are encouraged to build on their strengths so that over time they can increase their involvement in community activities. Programs should be flexible enough to accommodate transitional periods during which a participant may test moving out of the program with the knowledge that it is still available to him or her should the need arise.

Program activities should include those that assist participants to understand how mental illness and its consequences affect their lives, to understand its relationship to stress and to identify ways in which stress can be minimised and stressors recognised. These activities may be provided by the psychiatric disability support service or jointly with community mental health service staff, individually or in groups.

Informal Drop-In

Informal drop in emphasises social and recreational activities to promote peer networks and reduce community isolation. It aims to engage participants by encouraging attendance without requiring formal commitment. Informal drop-in is often the major source of enjoyment in participant's lives and its informal nature lends itself to innovation, creativity, peer support and experimentation.

In spite of the apparent informality, effective drop-in requires some of the most intensive and sophisticated work from staff, as many of the participants have multiple disabilities and long histories of institutionalisation.

Activities may be *centre-based* (eg coffee and chat, billiards, card games, women's social group) as well as *community-related* (eg, films, concerts, camps, barbecues/picnics in parks, visits to galleries, zoo, museums, etc).

Participants are encouraged and supported to organise and run their own social and recreational activities eg by holding regular meetings, contributing to planning and policy development in relation to program activities and participant interaction. (These may be separate or combined with the structured program's forum).

Services should support participant directed activities, eg extending invitations for representatives from a wide range of community organisations and services to meet with and address participant/members' issues.

Participants should also be involved wherever possible in prioritising program activities, investigating resource implications, running activities and evaluating activities. This creates an environment that fosters the development of trust, increased self-esteem and self-confidence and independence for participants.

Drop-in may be used by past participants of the structured program, as a way of continuing contact with the service, even though they are accessing other services or participating in the community in other ways, such as through employment. It can also act as a pathway to participate in more structured programs, and where appropriate, participants should be assisted to make this move.

Encouragement should take place in the context of a participant's goals, strengths and need for challenges outside the drop-in environment. This assistance may include joint activities in instances where structured programs and drop-in are discrete service elements. It may involve an orientation to structured programs by staff and participants in structured programs who have used drop-in previously. However, it is important not to foster a sense of 'graduation' from drop-in to structured program in a manner which allows a perception to develop of 'failure' should that transfer not occur.

Community Access

Community access involves community education, secondary consultation, referral, and advocacy by PDRSS staff. The aim is to facilitate participant's access to, and participation in, external community activities, services, social and recreational networks.

Outreach support

Outreach support involves key workers visiting participants of the day program in their own homes to provide psychosocial rehabilitation. This is important where a participant is too unwell to attend the day program and assists in maintaining links with the service.

5.2 Home Based Outreach Support

Aim

Home Based Outreach Support aims to reduce isolation, assist with learning or re-learning the activities of daily living, the development of social skills and the facilitation of access to community services.

Target Group

People with a psychiatric disability as a result of a severe mental illness. People who need one-to-one support and/or need support to maintain accommodation.

For services providing home based outreach support funded under the Mental Health Homelessness Program, the target group must also be homeless (refer mental health homelessness program – intensive home based outreach support guidelines).

Program Operation

Location

A major service focus for home based outreach support is the development and delivery of structured *social and living skills* programs in the person's own home, regardless of where the person lives and the nature of that accommodation. It therefore includes private or public housing, rooming and boarding houses, supported residential services, private hotels or caravan parks. *Home* is defined by the client. Clients may live alone, with family or with others.

Support may also be provided in community settings where one to one support is necessary, for example assistance accessing education, transport or recreation activities.

Opening Hours

Programs are expected to provide services five days a week and 52 weeks a year. The hours of operation should reflect the needs of participants. Intensive home based outreach support services are expected to provide some extended hours coverage.

Service Description

Home-based outreach support provides psychosocial rehabilitation and disability support to people in their own homes.

Service Components

Individual Support – Social and Living Skills Program

The major focus is on the development and delivery of structured social and living skills programs in the person's own home. The programs focus on activities and interactions of everyday life, eg. managing money and financial transactions, budgeting, buying, cooking, healthy living skills, personal care, caring for one's home environment, making and keeping social and recreational contacts, and relating to friends, family, neighbours and local businesses.

Emphasis is placed on active engagement and the development of a relationship of trust between the outreach support worker and the client, using non-coercive, flexible outreach methods that respect client privacy. This may mean calling in, by arrangement, for coffee and conversation on a number of occasions prior to the negotiation of a psychiatric disability rehabilitation and support service IPP.

Working with families

Where clients live with their family or other carer/s, the key worker will be respectful of all residents in the home and involve carers in the collaborative development of Individual Program Plans (IPP) (where participants consent to their involvement).

Support for Public Housing tenants

The support may be provided in the context of the Housing and Support program, where the service has tenancy nomination rights for a number of public housing properties; or where the client has accessed housing through the supported housing segment of the segmented waiting list.

An important part of this support is assisting the client to meet their requirements under the tenancy act. Services should aim to develop a good relationship with the tenancy manager, and in consultation with the client, develop a protocol for alerting the support worker when tenancy issues arise.

Group activities

Some planning and delivery of service programs at a central, communal location is desirable as the individualised nature of home-based support makes it difficult for participants to engage in service planning, to provide and receive peer support and acceptance, and hear each other's views. These may include social and recreational group activities such as barbecues, film nights, camps, picnics and meals out.

Production and distribution to clients/tenants of material such as newsletters assists in preventing isolation and encourages peer support.

5.3 Residential Rehabilitation

Aim

To assist participants to develop social and daily living skills, maximise independence and dignity, encourage them to participate in the life of the community and to develop the confidence and ability to move on to independent living.

Target Group

Residential rehabilitation services are suitable for people who:

- Will benefit from, and desire, intensive rehabilitation prior to living independently;
- Can live in a congregate living situation;
- Need assistance with making the transition from institutional dependency to community based support.

The level of support required for this group is greater than that can be provided by a home-based outreach service, or where home based outreach is not appropriate.

The specific characteristics of the target group will depend on the purpose of the residential rehabilitation program. Some target people with high or more complex needs. Some are only for people aged 16 – 25 years.

A need for housing should not be the sole basis for referral.

Program Operation

Location

Residential rehabilitation services are usually located in suburban streets. Opportunities should be provided for participants and neighbours to interact and share local interests.

Opening Hours

Residential rehabilitation services operate all year. Services may have 24 hour staffing with sleepovers or an on call system as appropriate to the needs of the residents.

Service Description

Residential rehabilitation services provide a transitional home environment where participants can learn the skills of daily living in a group setting amongst peers.

A residential rehabilitation service is appropriate where more intensive *rehabilitation* is required prior to a participant living independently in his or her own accommodation. It differs from general home-based outreach support by being able to provide a greater intensity of support.

Participants may enter residential rehabilitation services following an acute in-patient admission, particularly if the participant is a young adult with a recently diagnosed mental illness. Referrals may also be made from a clinical Community Care Unit where a participant may have already been involved in rehabilitation and treatment. Clinical community mental health services such as Mobile Support and Treatment Services usually provide ongoing clinical case management, assessment and treatment.

Residential rehabilitation services operate within a rehabilitation framework that recognises the potential for personal growth and the right to opportunities that support that growth. This model requires a commitment by residents of typically one to two years to enable a process of individual growth and change leading to an enhanced quality of life.

Service components

Strategies used by residential rehabilitation services may involve one-to-one and group work, peer support and unstructured time. The focus is on providing a flexible, individualised approach to meet individual needs within a group residential setting and through encouraging use of community services.

The resident's exit from the service should be planned carefully in advance with the resident. Links with the resident should be maintained, where appropriate, particularly during the transition period when they leave the service and move into more independent living arrangements, such as housing with home-based outreach support or shared accommodation.

5.4 Supported Accommodation

Aim

To provide a home like environment which maximizes independence and dignity.

Target group

People with a psychiatric disability as a result of severe mental illness. The target group is similar to residential rehabilitation, except that the desire and willingness to participate in an extended rehabilitation program is not required.

Program Operation

Location

Supported accommodation services are usually located in residential areas. Some services will be purpose built.

Opening Hours

Supported accommodation services are open all year. Supported accommodation services may have 24 hour staffing or operate an on call system.

Service Description

Supported Accommodation services provide long term linked accommodation and support. While services are delivered within a psychosocial rehabilitation framework, it is not necessary for people to actively engage in a rehabilitation program to be eligible for the service. Supported Accommodation services recognise that some people prefer to live in a structured supportive environment and do not want to participate in a transitional program.

Some supported accommodation services are also registered as Supported Residential Services and must meet the requirements under the Health Services Act.

Supported accommodation services are likely to provide assistance with activities of daily living, such as meals provision and housekeeping services. While services should work within a psychosocial rehabilitation framework and promote independence, the aim of service provision is not necessarily independent living.

5.5 Planned Respite

Aim

To support the caring relationship by reducing carer stress and assist in sustaining relationships between people with a psychiatric disability and their families or other carers.

Target Group

People with a psychiatric disability and their carers. Priority for planned respite should be given to carers and people with a psychiatric disability who are not engaged in other psychiatric disability support programs.

Only people with carers are eligible to access planned respite programs funded since 1996/97.

Program Operation

Location

Planned respite services may be provided at centre-based facilities, such as established camps or residential facilities, in a person's own home or in the community. Planned respite is not exclusively residential, rather flexible and innovative responses to respite needs are encouraged.

Opening Hours

Planned respite services should operate five days a week, 52 weeks a year. Services should aim to provide some extended hours services, including overnight.

Service Description

Respite may be provided in a range of service types, in a range of service settings, for differing periods of time and to achieve different goals.

Planned Respite Services provide people with a mental illness and/or their carers with an opportunity for a break. Some planned respite services funded before 1996/97 do not involve the carer and provide an opportunity for a person with a mental illness to have new experiences away from their usual living arrangements.

An important element of planned respite care is that the person with a mental illness is engaged in meaningful activity. All participants and their carers should receive a comprehensive assessment to determine the most appropriate respite option. Where possible, the planned respite experience should be consistent with the goals set out in the individual program plan.

Planned respite services include formal and informal psychosocial rehabilitation components. The provision of planned respite care may form a component of the person's Individual Program Plan. The decision to provide a planned respite care service to an individual may therefore be based on the needs of the person with the disability, or on the circumstances of their usual carer. Both can benefit from planned respite.

With the participant's permission, the respite care disability support worker should engage the referrer in discussions regarding the type of respite care desired by the participant. In the case of carer respite services, respite must be planned in consultation with the carer and participant.

Service Components

Planned respite can be delivered in a number of ways:

- *Regular planned respite* occurs in a planned and predictable way from the perspective of participant, carer and the service provider. It can be organised some time prior to the respite occasion.
- *Occasional planned respite* occurs in response to a specific need for alternative care and is usually a 'one-off' arrangement that may recur on an infrequent basis. A planned holiday for the carer or sitting for exams are examples. Participants also may choose this form of respite as a means of "keeping well" at times of need.
- *Short notice respite care* occurs when a carer or participant has an unexpected need for respite. Illness of the carer or in the carer's family, or a carer's job interview are examples.

Respite may be provided through:

- *Community activities*, such as day/overnight stays, camps and vacations, accompanied by support staff.
- *Day-based activities*, with the participants returning home at night.
- *In home respite* where the respite support worker visits people in his/her own homes to allow carers to have time to themselves for leisure or other needs.
- *Residential settings* with social and recreational opportunities in the community with some psychosocial rehabilitation activities available.

Respite may also occur when both a participant and carer(s) wish to engage in a shared respite activity together with the support of a respite worker. This may take the form of a day outing or holiday, with the goal being to refresh and strengthen the relationship between the carer and participant. All such respite activities must reflect the principles of psychosocial rehabilitation. Additional individually tailored services may also be purchased using respite funding.

5.6 Mutual Support/Self-Help

Aim

To provide support, education, information and advocacy services that assist people affected by mental illness to develop knowledge, skills and support networks that contribute to

recovery and reduce the negative impacts of mental illness.

Target Group

People affected by a mental illness (including people with mental illness, carers and anyone directly affected by or involved with someone with a mental illness).

Program Operation

Location

Mutual Support and Self-Help Programs include a range of different structures and operations, from small, locally run support groups to statewide, specialist organizations that provide several types of support services. Support and self-help groups usually meet in local community settings – such as neighbourhood houses, community health services, psychiatric disability support services and clinical mental health services. Statewide organisations often operate from a central base from which support, information and educational services are provided, and also auspice a number of support groups and networks in metropolitan and rural areas.

Opening Hours

The availability of mutual support and self help services varies depending on the service. Funded state-wide organisations are usually contactable 9 – 5, Monday to Friday, but also often include a number of support services that are available after hours and on the weekend – such as support groups, telephone helplines, social groups and educational activities. Small, locally run support groups may only be available after hours, or at the time of a meeting and may be time-limited.

Service Description

Mutual support and self-help services provide support, education, information and advocacy services that assist people affected by mental illness to develop knowledge, skills and support networks that contribute to recovery and reduce the negative impacts of mental illness.

Services and programs with an emphasis on *Mutual Support* provide opportunities for people with common needs and problems to draw upon and share the support, resources and knowledge of all for the benefit of all. By sharing experiences about the impact of mental illness in their lives, people are able to gain greater insight into, and understanding of, their difficulties and issues, and learn alternative and constructive approaches to dealing with the impact of the mental illness. Outcomes for people who participate in mutual support and self-help programs include: abatement of feelings of guilt, shame and fear; greater knowledge about mental illness, effective treatments and self-help strategies; reduced social isolation and feelings of alienation; strengthening of hope, self-respect and self-reliance; and diminished distress and confusion for all affected by the mental illness.

Self-Help refers to the need for, and ability of, individuals that have been affected by mental illness to exert control and choice over their own lives. The concept of self-help recognizes the inner capacities and strengths of individuals affected by mental health problems, acknowledges the expertise they have gained about their own issues through their lived experience, and values and validates their own part in the recovery process. Self help services assist people to access information, referral and support that will improve their knowledge and understanding of their mental illness and/or how mental illness affects their lives.

Mutual support and self-help programs aim to offer people a process of engagement with the issues associated with mental illness. People affected by a mental illness make contact with the service to obtain support and information, join a support group, participate in education programs or use a telephone support service. As issues resolve for people, they may wish to use their experience to support others in groups or through community education and advocacy.

Mutual Support/Self-Help services rely on a substantial amount of program support being provided by volunteers. Resources are allocated in the program to equip people with the skills to provide these services, with a significant proportion of paid worker time and organisational resources being devoted to the training and supervision of volunteers, many of whom are themselves in the process of recovery.

Service Components

Support Groups

Support group membership usually consists of people experiencing problems related to a specific illness, condition or disorder and/or their families and other carers. Some groups may focus only on issues for consumers, families or other carers rather than both. Alternative forms of support groups may be offered, such as telelink groups, pen pal networks and internet chat groups. Social groups and activities may also be offered as an adjunct to the support groups. Some Mutual Support and Self-Help programs, in particular statewide organizations, provide support through telephone helplines or face-to-face meetings.

MSSH programs and activities are often managed by a committee that includes members with a common special interest and who are themselves users or former users of the service. The service is frequently developed and delivered by members of such a special interest group. Funded statewide organizations generally employ professional and administrative staff to coordinate and manage the delivery of services, and facilitate the development of policies, standards and training to ensure consistent quality and ethical practices are maintained. Program managers generally put significant time and effort into promoting a collaborative approach to the needs of people affected by mental illness and to enable a sharing of expertise and resources. This can involve creating and maintaining strong links and partnerships with local community and primary health care services and relevant academic, research and clinical mental health services.

Information and Referral

A key focus of Mutual Support/Self-Help services is the provision of easily accessible and readily available **information and referral**. **Information** may be disseminated through a phone information service, publishing and distributing newsletters, writing and publishing fact sheets and pamphlets and by delivering talks, workshops and lectures. The service may also provide a library service and host a web site and email service, to promote information to the wider community.

These services also provide **referral** to quality services and practitioners with expertise in a particular area as well as referring individual clients to particular services in their local area.

Education and Advocacy

Mutual support and self-help programs that are funded as statewide specialist organizations provide a number of other services. These include: **recovery and coping skills programs** for consumers or families and other carers; **advocacy** for individuals or the wider constituency of the group; and **education, training and consultation** for professionals and agencies providing mental health services.

5.7 Carer Support

Aim

Carer support assists carers, families and friends of people with a mental illness through the provision of information, financial assistance and general support.

Target Group

Family members and friends of a person with a mental illness whose lives are affected by the mental illness. Carers may not necessarily live with the person for whom they care, and may be children of parents with a mental illness, parents of adults with a mental illness or otherwise involved with someone with a mental illness.

Program Operation

Location

Carer support can occur in the carer's home, PDRSS or in the community. Carer Support Workers are located in Commonwealth Carer Respite Centres across Victoria.

Service Description

Carer Respite Centres provide information about the range of services and support available for carers of people with a mental illness, links to relevant public mental health services as well as relevant information and resources. Carer Support Workers can assist in arranging respite and provide links to Mutual Support and Self Help groups.

Families and friends play vital roles in supporting people with a mental illness. They are important partners with mental health services in improving the health and well being of the people for whom they care. Providing support to the carer strengthens the caring relationship and assists the provision of mental health services in the community.

6. DEFINITIONS

Carer	<p>A person caring for a person with a mental illness. This may include a family member, friend or other person who has a significant role in the life of the person with a mental illness.</p> <p>The role of carer may not necessarily be a static or permanent one but may vary over time according to the needs of the consumer and carer. Paid carers such as professional staff in services, attendant carers or residential workers are not included in this definition.</p>
Case Manager	<p>A worker in a clinical mental health service who is the central point of contact and assists the person with a mental illness and their family/carers make the best use of services.</p>
Key Worker	<p>A worker in a psychiatric disability rehabilitation and support service who assists the person with a mental illness to develop an individual program plan and to reach his/her stated goals.</p>
Mental Illness	<p>‘Mental illness’ is a general term that refers to a group of illnesses. It is a medical condition characterised by a significant disturbance of thought, mood, perception and memory.</p> <p>A psychosis is a condition caused by any one of a group of illnesses that are known, or thought, to affect the brain causing changes in thinking, emotion and behaviour. These include schizophrenia and bipolar mood disorder.</p> <p>Other mental illnesses include phobias, anxiety, some forms of depression, eating disorders and obsessive compulsive disorders.</p>
Psychiatric Disability	<p>A psychiatric disability is the consequence of having a mental illness that affects a person’s ability to perform the tasks of everyday living and to develop and maintain effective personal and social relationships.</p>

7. ABBREVIATIONS

Abbreviation	Full Name
CCSP	Carer Crisis Support Program
CMHS	Community Mental Health Service
CCU	Community Care Unit
CQI	Continuous Quality Improvement
CSTDA	Commonwealth State and Territory Disability Agreement
DHS	Department of Human Services
GP	General Practitioner
HACC	Home and Community Care
HBOS	Home Based Outreach Support
HIR	Housing Information and Referral Service
IPP	Individual Program Plan
MDS	Minimum Data Set
MSSH	Mutual Support and Self Help
MSTS	Mobile Support and Treatment Service
PCP	Primary Care Partnership
PDRSS	Psychiatric Disability Rehabilitation Service
QDC	Quarterly Data Collection
SAAP	Supported Accommodation and Assistance Program
THM	Transitional Housing Management
VICSERV	Psychiatric Services of Victoria

Appendix A

Psychosocial Rehabilitation Principles

The fifteen Principles, which are used as a basis for the delivery of psychiatric disability rehabilitation and support in Victoria, are:

1. Under-utilisation of full human capacity:

All people can work towards a series of goals when those goals are personally meaningful. (Carling & Broskowski, 1986)

Life is a process of growth and change and all persons, even the most severely disabled, are capable of growth and change. (Nirje, 1969)

2. Equipping people with skills (social, vocational, educational, interpersonal and others).

It is the presence or absence of skills, not clinical symptoms, that is the determining factor in rehabilitation success (Anthony, 1977; Anthony, Cohen & Vitalo, 1978)

Clients are able to extend their repertoire of skills and to generalise their use to other settings, except in clinical ones. (Wallace et al., 1980; Liberman et al., 1986)

3. People have the right and responsibility for self-determination

Individuals have the right and the ability to participate in making decisions regarding their lives and to do so on a regular basis (Cnaan et al., 1988)

People with emotional disabilities should participate in the management of the agency, along with staff, in all levels of planning, policy making, implementation and evaluation. (Smith, Brown, Gibbs, Sanders & Cremer, 1984; Holland, Konick, Buffum, Smith & Petchers, 1981, Smith & Ford, 1986: in Cnaan et al., 1988)

4. Services should be provided in as normalised environment as possible.

Each individual has the right and is expected to live and function in the setting that is least restrictive and that as closely as possible approximates a regular community setting....skills must be taught in vivo. (Cnaan et al., 1988)

5. Differential needs and care.

Because of the diversity of people's needs, individualisation of the rehabilitation plan is needed.... There is no planned, predicted and gradual

manner by which all or most clients progress, but rather, each has a unique track of progress and regression. (Cnaan et al., 1988)

6. Commitment from staff members.

Even when clients are losing their determination, staff must be expected to persist in the belief that progress is feasible. (Cnaan et al., 1988)

7. Care is provided in an intimate environment without professional, authoritative shield and barriers.

The human element in staff performance is a crucial part of the rehabilitation process. (Anthony, 1977, 1982)

....the intervention cannot be mysterious to the client. The practitioner is constantly trying to demystify the rehabilitation process. (Anthony et al., 1982)

8. Early intervention.

9. Environmental approach.

The immediate environment of each person should be structured to provide support. The emphasis is upon the environment and the creation and enhancement of supportive elements within the environment. (Easton, 1984)

10. Changing the environment.

PSR advocates ...restructuring and reeducating the environment....One of the yet unclear and undetermined issues in PSR is to what extent the environment should be altered. Estroff (1983) has clarified the challenge of this dilemma by claiming that only radical work can justify the term "social" in psychosocial rehabilitation. (Cnaan et al., 1988)

11. No limits on participation.

12. Work-centred process.

The PSR approach believes that work, especially the opportunity to aspire to and achieve gainful employment, is a deeply generative and reintegrative force in the life of every human being. (Cnaan et al., 1988)

13. There is an emphasis on a social rather than a medical model of care.

PSR . . . stresses skill-building and social support systems to assist persons to be better equipped to deal with life's stresses.... PSR requires an ethos of health, expectation of recovery and challenge and a practical orientation offering individual autonomy and responsibility. (Easton, 1984 in Cnaan, 1988)

There is a difference between treatment (medical term) which focuses on the client's impairment and rehabilitation (PSR) term which focuses on utilizing the person's strengths and abilities for overall better independent functioning and fulfillment of social roles. (Cnaan et al., 1988)

14. Emphasis is on the client's strengths rather than on pathologies.

15. Emphasis is on the here and now rather than on problems from the past.

(Principles 14 and 15 were added by the 1990s as they were believed to be integral to the processes of psychosocial rehabilitation).

References:

Anthony, W. A. 1977 Psychological rehabilitation: A concept in need of a method, *American Psychologist*, 32 (8), 558-662.

Anthony, W. A. 1982 Explaining psychiatric rehabilitation by an analogy to physical rehabilitation, *Psychosocial Rehabilitation Journal* 5 (1), 61-65.

Anthony, W. A., Cohen, M. R & Vitalo, R. 1978 The measurement of rehabilitation outcome, *Schizophrenia Bulletin*, 4 (3), 365-383.

Anthony, W. A., Cohen, M. & Farkas, M. 1982 A psychiatric rehabilitation program. Can I recognise one if I see one?, *Community Mental Health Journal*, 18 (2), 83-96.

Carling, P. J & Broskowski, A. 1986 Psychosocial programs as a challenge and an opportunity for community mental health centres, *Psychosocial Rehabilitation Journal* 10 (1), 39-48.

Cnaan, R., Blankertz, L., Messinger, K. W. & Gardner, J. R. 1988 Psychosocial Rehabilitation: Toward a Definition, *Psychosocial Rehabilitation Journal*, 11 (4) 61-77.

Easton, K. 1984 Psychoanalytic principles in psychosocial rehabilitation, *Journal of the American Academy of Psychoanalysis*, 12 (4), 569-584.

Holland, T., Konick, A., Buffum, W., Smith, W. K. & Petchers, M. 1981 Institutional structure and residential outcomes, *Journal of Health and Social Behaviour*, 22 (4), 433-444.

Lieberman, R. P., Mueser, K. T., Wallace, C. J., Jacobs, H. E., Eckman, T. & Massel, H. K. 1986 Teaching skills in the psychiatrically disabled: learning coping and competence, *Schizophrenia Bulletin*, 12 (4), 631-647.

Nirje, B. 1969 The normalization principle and its human management implications in R. Kugel (Ed.), *Changing patterns in residential services for the mentally retarded*. Washington DC.

Smith, M. K. & Ford, J. 1986 Client involvement: Practical advice for professionals, *Psychosocial Rehabilitation Journal* 9 (3), 25-34.

Smith, M. K., Brown, D., Gibbs, L., Sanders, H. & Cremer, K. 1984 Client involvement in psychosocial rehabilitation, *Psychosocial Rehabilitation Journal*, 8 (1), 35-43.

VICSERV, *Psychiatric Disability Support: A Resource Book*, 1998

Wallace, C. J., Nelson, C. J., Liberman, R. P., Aitchinson, R. H., Lokoff, D., Elder, J. P. & Ferris, C. 1980 A review and critique of social skills training with schizophrenic patients, *Schizophrenia Bulletin*, 6 (1), 42-68.

Appendix B

Principles for the Delivery of Community Based Mental Health Services

- Flexibility of structure and service model
- Non-obligatory attendance
- Support for mobility and choice of service options
- Active participant involvement in services
- Support for participant decision making
- Concentration on quality of relationships and interactions between participants and staff
- Encouragement of peer support
- Responsiveness to participants needs
- Provision of most normal environment
- Effective psycho-social rehabilitation
- Autonomous community accountability
- Utilisation of a broad range of skills
- Active community education function
- Active advocacy function
- Cost-effectiveness: both operational and preventative

(VICSERV: 1998)

Appendix C

Key Service Requirements of PDRSS

The following key service requirements are for all Psychiatric Disability Rehabilitation and Support Services, except mutual support and self-help.

The key service requirements are:

- To provide flexible, responsive programs which:
 - respond to individual identified needs;
 - enhance quality of life, self esteem and sense of well being;
 - enhance social and daily living skills, capacity for independent living and involvement in community life;
 - enhance social relationships, including relationships with families and carers;
 - provide opportunities for participants to develop and maintain social, recreational and support networks;
 - promote integration of people with psychiatric disabilities in the local community; and
 - are provided in the least restrictive setting.
- To work collaboratively with participants, and their carers (when appropriate), to develop an individual program plan (IPP). The IPP will identify needs, goals and strengths and articulate a process to assist the participant reach their goals.
- To allocate a key support worker to each participant upon entry to the service, facilitate the development of an IPP within two months and review the IPP as needed but at least every six months
- To provide continuity of care for participants by establishing and maintaining cooperative links with other mental health and general health and community services areas, by establishing key worker/case manager collaboration and by the effective use of referral, liaison and networking.
- To seek opportunities to provide services in collaboration with other community services and in community locations.
- To provide opportunities for people with psychiatric disabilities, and their carers, to be involved in the development and evaluation of programs in which they participate.
- To provide community education and awareness of psychiatric disability in order to decrease discrimination, facilitate community acceptance of participants and improve participant's access to community services and facilities.
- To ensure that programs are culturally, age and gender sensitive and relevant to the needs of potential groups of service users and their families in the community.

Key Service Requirements of Mutual Support/Self-Help Services:

Mutual Support/Self-Help services may engage in some or all of the following activities. Some activities focus only on participants, families or carers.

- Provide access to information, education, support and referral to service users by telephone or personal contact and provide information by post or electronically as required.
- Provide opportunities for people experiencing the impact of mental illness in their lives (participants, families or carers) to meet and share experiences, receive input about the experience of mental illness and develop skills that support them and their family or carers.
- Promote community awareness of the incidence and effects on people of mental health problems or conditions, and the treatment, care and support available.
- Provide education about the experience of mental illness and the community supports that are available.
- Provide community education that focuses upon the promotion of mental health and the prevention of mental illness.