



Framework for Rehabilitation for Mental Health

Mental Health Implementation Group

*‘to acquire and
use strength and
skills, supports
resources’*

NSW HEALTH DEPARTMENT

73 Miller Street
North Sydney NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
www.health.nsw.gov.au

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For further copies of this document please contact:
Better Health Centre – Publications Warehouse
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Gladesville NSW 2111
Tel. (02) 9816 0452
Fax. (02) 9816 0492
TTY. (02) 9391 9900

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Message from the Director-General

The implementation of the *Government's Action Plan for Health* has been progressing at an impressive rate. The formation of **Statewide Clinical Implementation Groups** to progress the development and implementation of models of care aimed at improving critical, acute and mental health services, and care for people with chronic and complex conditions has been a significant step towards facilitating a better health system for people in NSW.

The *Framework for Rehabilitation for Mental Health* has been developed in response to the need for reform in structure and approaches to delivery of rehabilitation and support services. New thinking is emerging about what constitutes 'best practice' for rehabilitation that focuses on skill building, to help people with mental health problems to capitalise on their personal strengths, develop effective coping strategies, and develop supportive environments to maximise independent functioning.

Mental Health Services are encouraged to identify the full range of rehabilitation programs necessary for their communities, and to undertake these in collaborative partnership with consumers, carers and relevant government and non-government organisations (NGOs). Mental health services will be expected to provide programs that are directed towards the profiles of individual functional impairments and relevant strengths.

The *Framework for Rehabilitation for Mental Health* provides a template to assist public Mental Health Services and mental health NGOs with service planning, development and evaluation. A distinction between clinical rehabilitation and disability support has been included to assist services in this planning process.

I would like to express my thanks to the **Mental Health Implementation Group**, to the Non-Acute Working Party and its members, and to the many people who assisted in preparing this framework.

I commend to you the *Framework for Rehabilitation for Mental Health* and wish you well with its implementation.



Robyn Kruk
Director-General

Setting the Scene

Introduction

Mental health systems in many parts of the world are undergoing a significant reform in structure and funding mechanisms, that may lead to changes in approaches to the delivery of treatment and support services. Best practices in rehabilitation for mental health are changing in response to new knowledge from research, clinical practice, and consumer and carer sources¹.

The basic premise underpinning these reform activities is to ensure that rehabilitation services are delivered at the most appropriate level, in a timely fashion, and in the context of good outcomes for the best value. This includes making appropriate distinction between clinical rehabilitation and disability support, and determining which services should be provided by the non-government organisations (NGOs) and which services should be provided by Area Health Services.

Focusing on what can be done to achieve wellness rather than focusing exclusively on the severity of the disability is likely to improve health status, increase symptom stabilisation, and reduce overall welfare and health care costs.

The need for reform should be considered in the context of ever-growing demand for health services. It has been suggested that the health care needs of many people diagnosed with psychiatric disorders such as schizophrenia, major depression, anxiety disorder, personality disorder and bipolar disorder will have significant implications for the future performance of the health system². There is a strong case for establishing evidence-based and cost-effective programs to improve the quality of rehabilitation for mental health, and to provide a tool for planning and managing the performance of this aspect of the mental health system.

The link between effective rehabilitation, relapse prevention and shorter duration of psychiatric inpatient stays has been identified in several studies³. Studies of psychosocial rehabilitation (skills training and supported employment), for example, have shown an average reduction of more than 50% in cost of care due to reduced hospitalisations⁴. Some rehabilitation programs have demonstrated better outcomes than others, particularly those that lead to the re-entry of the individual into open or competitive employment (vocational rehabilitation).

What is rehabilitation for mental health?

Rehabilitation for mental health, also known as 'psychiatric rehabilitation', is a set of targeted interventions that is intended to prevent further, or reduce disability that is associated with mental health problems. It is a process of assisting people to acquire and to use the strengths and skills, supports, and resources necessary for successful and satisfying living, learning, and working in the environments of their choice⁵. Rehabilitation also plays an important role in reducing the despair and emotional suffering that often are associated with the early onset, chronicity and recurrent nature of mental illness, and its impact on families and carers.

'Our primary objective is to improve the quality of life for people with chronic and complex health conditions, their families and carers'.

NSW Health Council, March 2000

Rehabilitation for mental health involves two service components. Firstly, it refers to specific interventions that assist people to recover from mental illness by *improving* role functioning, increasing ability and, or, decreasing disability, and developing skills and resources that are specific to individual needs. These interventions are referred to as clinical rehabilitation. Secondly, rehabilitation refers to interventions that are aimed at the *maintenance* of role functioning, life skills and independence. These interventions are referred to as disability support.

NSW Area Health Services work in collaborative partnerships with NGOs and other organisations to provide various rehabilitation services for people with mental health problems, both in the community and in hospital settings.

The programs that are generally available include cognitive behavioural therapy, cognitive rehabilitation, vocational rehabilitation, supported employment, pre-vocational training, transitional employment, family intervention, skills training, illness self-management and psychosocial rehabilitation.

The need for an overarching policy framework for mental health rehabilitation

Recently, there has been an greater interest by policy makers, consumer and carer advocates, and service providers, in learning which models or elements of models for rehabilitation for mental health are the most effective in delivering the desired outcomes. This interest has grown since the advent of both the community and consumer movements; structured skills programs previously were provided only within large psychiatric institutions. The need for policy development and a rethinking of existing practices has been identified.

The *Framework for Rehabilitation for Mental Health* is a policy statement that is intended to guide policy and planning initiatives at the Area Health Service level and at the level of local facilities, as well as the policy and planning initiatives of NGOs that are involved in the provision of mental health services. It seeks to minimise fragmentation of service delivery, and to link the various aspects of rehabilitation and support services to promote continuity of care. These objectives are consistent with the reviews of the NSW health care system, that were commissioned by the Minister for Health in 1999^{6,7}.

The *Framework for Rehabilitation for Mental Health* involves a commitment at policy and service levels to the prevention of psychiatric disability. It is intended to assist people with psychiatric disorders and disabilities with rehabilitation and recovery. The role and specific functions of clinical rehabilitation and disability support, together with recommendations for affirmative action for individuals with special requirements for support, will be considered further in this framework.

Target audience

The *Framework for Rehabilitation for Mental Health* has been developed for several target groups and key stakeholders in the NSW health care system:

- clinical staff, managers and support staff public and private health services who are involved in clinical rehabilitation and disability support, health planners, general practitioners, NGOs and other government departments
- consumers, their families and carers⁸
- policy makers and funders of mental health rehabilitation services.

What is happening now?

Review of the NSW Health Care System

The *NSW Government's Action Plan for Health* arises from findings in the two reports – *Report of the NSW Health Council*⁹ and *Report of the Ministerial Advisory Committee on Health Services in Smaller Towns*¹⁰. These reports identify priority areas for the NSW health system. The areas for which system-wide reforms are necessary include increasing access to health care, enhancing service delivery in rural areas, improving coordination between acute and non-acute sectors of the health systems, and improving the use of information systems.

If these issues are addressed, health services will be better able to manage the increasing demand for health care, and identify where the greatest contribution can be made to improve the quality, effectiveness and efficiency of care provided by the NSW health system to consumers of mental health services.

Implementation Coordination Groups

As a result of the review, Implementation Coordination Groups for mental health, chronic and complex care, emergency services, intensive care and acute care have been established. These groups will facilitate a consistent statewide approach to best practice in health service delivery for people with long-term and, or, complex needs for care.

Priority health care programs have been funded in the provision of new models for more effective care for people with chronic conditions. Examples of these programs include treatment and care for people with cancer, respiratory disease and cardiovascular disease.

The work and function of the Chronic and Complex Care Implementation Coordination Group has a distinct interface with the *Framework for Rehabilitation for Mental Health*, which is the responsibility of the Mental Health Implementation Group. This responsibility includes the role of the Mental Health Implementation Group in overseeing, monitoring and evaluating Area Health Services' use of funds to achieve best-practice standards of health care for people of all ages with chronic and complex care needs¹¹.

Mental Health Implementation Group

The successful implementation of the *NSW Government's Action Plan for Health* depends on the development of a *Framework for Rehabilitation for Mental Health*, which the Mental Health Implementation Group has agreed to undertake. This initiative is a major part of the work of the affiliated Non-Acute Working Party. The model, which draws together the different aspects of best practice in the provision of rehabilitation for mental health in NSW communities, is illustrated in Appendix A.

The framework presents some of the guiding principles of rehabilitation, and identifies 'core' good practices and basic requirements or elements of effective rehabilitation. It will assist in the development of new services and guide service redevelopment and continuous quality improvement in this field.

The framework needs to be viewed in the context of the following related policy initiatives for the provision of non-acute mental health services, as undertaken by the Non-Acute Working Party:

- *Housing and Accommodation Support for People with Mental Health Problems and Mental Disorders*, a strategic framework that seeks to address the issue of housing and accommodation support services.

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2 Principles for the provision of rehabilitation for mental health

The following underlying principles for the provision of rehabilitation for mental health in NSW Mental Health Services and NGOs have been developed for the framework¹²:

- All services and individual care will be planned and implemented collaboratively with consumers, to achieve optimal outcomes.
 - The roles of families and carers will be acknowledged, supported and valued.
 - Programs will be targeted and evidence-based, supported by appropriate information systems, and be evaluated, and their outcomes will be documented.
 - Demonstrated skill and commitment to evidence based, good practice will determine which organisation provides each aspect of the program.
 - Rehabilitation programs will assist people to achieve the best possible quality of life, building strengths and lessening functional disability.
- Planning processes will be established with relevant departments and agencies to achieve agreed targets and outcomes.
 - Service agreements that describe structures that facilitate timeliness and access will be established with relevant departments and agencies.
 - Individual need for rehabilitation, including clinical and disability support requirements, will be identified, and standardised entry and exit criteria for services will be established.
 - A whole-of-person response is required to address comorbidity, compounding problems and complex disabilities.

‘Every person with a mental illness shall have the right to live and work, to the extent possible, in the community’.

UN Principles for the Protection of Persons with Mental Illness, Resolution 46/119, December 1991

What is needed is an overarching, coherent policy framework that serves as a template for providing rehabilitation in a systematic way in NSW Mental Health Services. The template should include links to current best practices in general rehabilitation settings, which are relevant to the prevention and management of disability that arises from illness and injury.

A key feature of the framework is the provision of effective rehabilitation programs that include individual assessment and goal setting, and are undertaken in collaboration with the consumer. Such programs will be delivered together with targeted interventions that are intended to improve individual strengths and social, communication, domestic, leisure, vocational and self care skills, sleep and rest, and coping with grief and loss. These programs and interventions should be delivered in partnership with the people who need support, and their families and carers. The framework will also consider people with special needs.

Rehabilitation and disability support interventions generally are undertaken by specific rehabilitation teams, rehabilitation experts, other Area Mental Health staff, NGOs, general practitioners (GPs), private psychiatrists, other government agencies, and various combinations of these providers. As part of the new framework, rehabilitation programs will be governed at the clinical level by Rehabilitation Development Groups. This governance will lead to better service integration.

Each Rehabilitation Development Group will need to have a commitment to promoting access to and progress through the mental health system for people with complex and ongoing health care needs, which is consistent with the work of the NSW Chronic and Complex Care Implementation Group. Moreover, as a priority, each Rehabilitation Development Group will need to delineate roles for rehabilitation and disability support services that take into account issues that are relevant to their Area Health Service.

Role delineation will highlight the importance of collaborative partnerships between public sector and NGO services, to ensure better health outcomes and more accessible rehabilitation and support services. Such organisational arrangements will ensure access to resources that strengthen self-determination and self-sufficiency by promoting health and wellness, improvement and recovery, quality of life and dignity¹³.

Suggested objectives and membership for a Rehabilitation Development Group have been included in Appendix B.

The new framework: a range of rehabilitation interventions is needed

A focus on wellness

A person who feels well can accomplish the tasks of every day living and achieve desired life goals. The ability to manage wellness and illness involves individual empowerment and personal capacity building, through consumer participation and ownership in the rehabilitation process¹⁴.

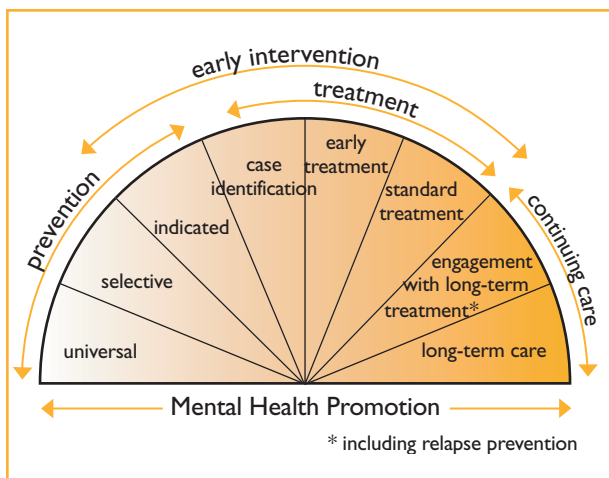
The primary function of rehabilitation is to improve role performance and status in a person's living, learning, working and social environment. The *Framework for Rehabilitation for Mental Health* seeks to assist individuals with mental health problems to achieve a level of wellness that promotes symptom management, prevents relapse, reduces the need for hospitalisation, and assists integration back into community life through the achievement of life goals.

It is important that the service providers included in this framework work collaboratively to facilitate early identification of mental illnesses. Early identification can lead to lesser disability, and can provide opportunities for mental health promotion that benefits individuals with a mental illness, their carers and families, and the broader population, to enhance wellbeing.

3 The spectrum of interventions for mental health problems and disorders

Timely intervention for people who need support may be particularly effective and even prevent the development of disabilities or lessen the degree of disability. In keeping with current policy and clinical trends in the provision of mental health care, the need for a framework for rehabilitation for a spectrum of interventions and disorders has been identified. The focus is on rehabilitation that begins early, as illustrated in Figure 1.

Figure 1. Spectrum of interventions



Adapted from Mrazek PJ, Haggerty RJ¹⁵

In Figure 1, assessment of rehabilitation needs begins at the earliest point of treatment, which is the ‘case identification’ part of the spectrum. It also involves the other spectrum components of treatment and continuing care, including long-term care.

Interventions from promotion to early intervention, to treatment, to continuing care (relapse prevention) for people with a mental illness, and prevention of the onset of mental illness, particularly for carers and families, are key aspects of the framework. Their application at the Area Health Service level is critical in planning local mental health services. This includes linking the planning of mental health rehabilitation services in each Area Health Service to population projections for service requirements, an approach for which is outlined in the Mental Health Clinical Care and Prevention Model¹⁶.

Meeting the needs for mental health rehabilitation of indigenous people, people from culturally and linguistically diverse backgrounds and people who live in rural and remote areas will require special attention, in particular in the development of collaborative partnerships with people who represent these groups. Rehabilitation frameworks developed at the Area level by Rehabilitation Development Groups will need to be sensitive to local cultural and social issues, and the specific needs of each group.

The target groups for whom improved service access and better service responses are essential are: young people, adolescents, older people, people with mental illnesses and intellectual disability, people with mental illnesses and problems with drug and alcohol misuse, forensic populations and people with a full range of mental disorder, including personality disorders. Further guidance is needed on the elements that should be included in programs for these groups, including the skills and resources required. The provision of this guidance will be a key planning issue for Rehabilitation Development Groups, and should be undertaken in consultation with consumer and carer groups, local Area Health Services and the Centre for Mental Health.

People who are homeless or at risk of homelessness are also included in this target group. Affirmative action for these populations is consistent with both state and Commonwealth public policies for mental health.

Rehabilitation for mental health: best available evidence

The following mental health rehabilitation interventions are available:

- cognitive focused interventions
- vocational rehabilitation
- supported employment
- pre-vocational training
- transitional employment
- family intervention
- individual goal oriented skills building
- illness self-management
- psychosocial rehabilitation
- compensatory strategies.

‘The essentials of rehabilitation are described as individualised care, attention to strengths, aiming to restore hope, addressing vocational potential, encouraging a full array of social and recreational activities and involving people in their own care.’

Bachrach, 1993

Clinical rehabilitation interventions should be seen as distinct from specialist disability support services, which are concerned with long-term support and maintenance of skills and abilities. However, both rehabilitation service components target the same issues but from different angles and orientation of goals. They are not mutually exclusive, and it is likely that an individual may access clinical rehabilitation while simultaneously receiving disability support services.

Mental health rehabilitation is provided in the following ways:

Skills building

Skills building involves learning activities that enable individuals to acquire the skills that are required to meet the interpersonal, self care, home maintenance, education, vocation, leisure, social skills and coping demands of community living. Training in these skills is a central element of short and long-term rehabilitation.

Social skills training has been shown to be an effective intervention with individuals with disability associated with mental illness. Social skills training is provided as individual, family or group therapy, and is best taught in the environment where these skills will be used^{17,18}. Social skills training that is structured, systematic and curriculum-based results in better outcomes than informal social skills training, such as discussion groups¹⁹.

Family intervention

Many international studies have suggested that the joint involvement of consumers and their families will optimise the acquisition of social and independent living skills. This includes education about the disorder, how to access professional and community services and training in (and application of) communication skills²⁰. Issues of trauma, loss and grief may also need to be dealt with.

Psycho-education may be conducted in groups of several families, to promote networking and better opportunities for transferring learned skills into other rehabilitation settings. Consumer participation in family psycho-education has demonstrated reduced illness relapse and hospitalisation. Psycho-education, combined with direct and behavioural interventions, and with skills training and environmental support, has also been effective in producing outcomes²¹.

Cognitive focused intervention

This therapeutic model can assist people with a range of mental disorders, including schizophrenia as well as depression in adolescents, to cope better with everyday life. It aims to contribute to cognitive function, such as more effective cognitive styles, and to improve individual cognitive deficits such as memory difficulties, poor concentration or a low attention span.

3

There are three main categories of cognitive focused intervention:

1. Cognitive behavioural therapy, which refers to therapies that aim to reduce dysfunctional thoughts, emotions and behaviour by altering thinking patterns and behaviours. This technique is based on the assumption that prior learning is currently having adverse consequences. The purpose of therapy is to reduce distress or unwanted behaviour by undoing this learning or by providing new, more adaptive learning.
Evidence suggests that cognitive behavioural interventions promote better outcomes than informal methods²². In addition, supportive psychotherapy (group and individual) has demonstrated better outcomes than ‘insight’ approaches for people disabled with schizophrenia²³.
2. Direct remediation of basic cognitive deficits, which involves behavioural training (frequently using a computer) to address cognitive functions such as reaction time, memory, span of apprehension and vigilance²⁴.
3. Cognitive adaptation training, using interventions that include going into people’s everyday environments, and involving very practical interventions (calendars, checklists, training) to promote desired behaviours and decrease undesirable ones²⁵.

Psychosocial self-help programs

These involve programs such as social clubs, clubhouse models and drop-in centres, as community-based psychosocial rehabilitation centres for people with chronic mental health problems. The Clubhouse model is an example of a non-medical focus for rehabilitation. Mood disorders self-help groups, depression and anxiety support groups, and eating disorders support groups, are other examples of self-help organisations that assist people who need support. Self-help groups aim to improve the quality of life for people with a mental illness, to promote supportive networks, and to ensure purposeful support and reinforcement of social capabilities.

‘While the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals.

The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational residential, social/recreational, educational and personal adjustment services.’

*International Association of
Psychosocial Rehabilitation Services, 2000:
Principles for Rehabilitation*

Traditionally, rehabilitation programs have focused on providing broadly-based interventions within the group setting. There is now general agreement in the literature that rehabilitation services need to be targeted to individual need. Many authors have cited the need to tailor programs to the specific goals and needs of the individual²⁶. The essentials of rehabilitation are described as individualised care, attention to strengths, aiming to restore hope, addressing vocational potential, encouraging a full array of social and recreational activities and involving people in their own care²⁷. Services also need to be flexible and responsive to changing needs²⁸.

In examining the literature available on rehabilitation it is also apparent that there is not a sole definition of the term ‘rehabilitation for mental health’. It is suggested the term be used primarily in two ways. Firstly, to describe a much less specific intervention and simply refer to non-specific general mental health services that may be provided to a person suffering a chronic illness²⁹. Secondly, to denote specific interventions that aim to improve the level of individual functioning, in effect the concept of rehabilitation promoted by the International Classification of Functioning and Disability (ICIDH-2)³⁰.

The ICIDH-2 classification provides a scientific framework which can be used successfully in clinical practice in mental health, and includes a focus on strengths and potentials.

Rehabilitation for mental health encompasses good clinical care, which also aims at promoting the fullest possible recovery. This includes access to timely early rehabilitation intervention, medication management and comprehensive clinical assessment and review, which are linked to better outcomes³¹. Another example involves the provision of intensive case management, such as that offered in the Assertive Community Treatment Teams, for selected clients. Several studies have linked intensive case management to better outcomes than those of standard case management (including hospital readmission, accommodation status, employment and consumer satisfaction measures)³².

Evidence-based outcomes for vocational and educational rehabilitation

Work and employment are of primary importance for people with mental disorders and psychiatric disabilities. Working and having a job increases people's satisfaction and self-esteem and breaks the cycle of poverty and dependence. Work also provides an opportunity to socialise and communicate³³.

The literature on rehabilitation for mental health contains strong arguments in favour of interventions that lead to the re-entry of the individual into open or competitive employment, and a service management system that incorporates well-defined pathways to recovery, involving both clinical rehabilitation and disability support services³⁴.

Vocational rehabilitation addresses people's capacity to work – pre-vocational training is designed to assist individuals with disabilities more generally in acquiring and maintaining work habits and work-related skills. A review of the evidence regarding the effectiveness of vocational rehabilitation – 18 randomised controlled trials – concluded that supportive employment was significantly more effective than pre-vocational training, in helping people find work; full- or part-time employment was defined as the primary outcome³⁵.

For example, some studies found that at 18 months, 35% of people under the supported employment approach were working in competitive employment compared with 12% of people in pre-vocational training. People in supported employment also earned more and worked more hours per month than people in pre-vocational training. There was no evidence that pre-vocational training was more effective in helping individuals to obtain competitive employment than standard community or hospital care.

The raising of awareness of mental health problems and the need for supporting the consumer in the recovery process in the workplace is a significant issue to be addressed by rehabilitation services³⁶. Furthermore, the need to focus on education and training during recovery from severe and persistent psychiatric disability has recently received a great deal of attention in the mental health rehabilitation literature³⁷. This includes the need to establish support structures for individuals – particularly young people – who may wish to undertake further education, such as tertiary studies, as part of their rehabilitation process.

Consumer empowerment and building personal strengths

The *Framework for Rehabilitation for Mental Health* advocates a model that focuses on promoting wellness, as well as appropriate management of symptoms. This includes the need for services to help consumers to maintain a stable level of wellness, prevention of additional relapse, improvement of self-concept, and empowerment of the consumer to build personal strengths to facilitate the rehabilitation process.

The goals of empowerment and promoting personal strengths further entail the need for services to assist in the gradual integration back into the community, including the ability to access support infrastructures such as housing and income support. Individual strengths also include the ability to self manage basic health, including rest, nutrition, exercise, and to utilise healthy coping mechanisms and improved interpersonal skills.

3

A template that outlines the range of mental health rehabilitation interventions that consumers will require access to at the Area level is included as Appendix C. The template provides guidelines for health services on the provision of rehabilitation, including how to design, develop and deliver effective interventions.

Vehicles for service delivery

Historically, mental health rehabilitation services have been arranged in various ways, including the more traditional facility-based programs that may be found in communities and hospitals, and the more recent services and supports that reflect the ways that people in a community typically live, work and relax.

Hunter Area Health Service has defined:

‘... clinical rehabilitation as the provision of evidence based interventions that will assist in the recovery process of those individuals who have a capacity and a commitment to change

‘... disability support as a general series of activities aimed at the long term support and maintenance of skills and abilities’.

*Psychiatric Rehabilitation Services Management Group
Hunter Area Health Service, 2001*

Recently, there has been an interest by NSW Health policy makers, consumer advocacy groups, and service providers, including NGOs, in identifying which of these models for service provision are the most effective in delivering the desired outcomes. Broadly speaking, clinical rehabilitation and disability support services typically have been provided by NSW Area Health Services and mental health NGOs within an overarching framework of disability support.

However, the interface between the two sectors is not clearly defined³⁸. The core public mental health services are community-based extended care

services, case management services³⁹ and hospital based residential rehabilitation for people with severe mental disorders, as well as inpatient extended care programs.

Other state government and Commonwealth Government departments also provide rehabilitation and support to people with psychiatric disabilities. The NSW tradition for collaboration across government departments has been important in ensuring equity and access to rehabilitation and disability support services, and in addressing the needs of a wide range of the individuals, in addition to those needs that have been met by the health system.

For example, the Commonwealth Rehabilitation Service assists people with a disability or injury to obtain and keep employment. The NSW Department of Housing provides tenancy support for people with psychiatric disabilities through the Office of Community Housing. Centrelink disability officers provide advice and links to disability employment assistance, and make referrals to other disability and carer organisations that can help with non-work related issues.

In determining which services are most suitable for the NGO sector and which are best managed by Area Health Services, it is useful to consider the following conceptual distinctions.

Clinical rehabilitation

Generally, it can be argued that acute care services and individuals requiring a high level of clinical expertise should remain in the specialised mental health sector. These include assertive community treatment, intensive clinical case management, and the various clinical interventions referred to in ‘The spectrum of interventions for mental health problems and disorders’ on page 10. Community mental health services are the vehicles for providing a range of appropriate interventions, often in partnerships with other agencies, including general practitioners, private psychiatrists, NGOs, and other government departments (ie the Department of Community Services, the Department of Education and Training, and the Department of Housing).

‘The two functions of long term support and rehabilitation are best provided separately to reduce the role confusion between promoting dependence (long term support) and reducing dependence (rehabilitation)’.

South Eastern Sydney Area Health Service, 1999

Mostly, the provision of non-acute inpatient mental health care and associated clinical support, including long-stay and forensic beds, remains the responsibility of the specialist psychiatric facilities. A strategic planning process that is linked to the Government Action Plan is currently underway. The process will address a range of service planning and clinical issues such as standardised pathways to care, best-practice protocols, benchmarks and funding frameworks⁴⁰.

Disability support

Services for individuals who seek support for their disabilities should be provided primarily in the NGO sector, consistent with NSW traditions in this field. An integral part of the development of this sector has been the commitment of individuals, consumer and carer groups, and organisations to advocate for the rights of people with psychiatric disabilities and enable improvement in opportunities and conditions for community living. The practical and skilled support that NGOs have provided at this local level has been valued by consumers and carers.

Disability support services are underpinned by a commitment to the principles of rehabilitation for mental health and a philosophy of providing programs that have not generally been available through the public health sector. Service provision includes assistance to individuals who need support to regain or develop the skills that they may require to participate actively in daily living, to interact personally and socially, and to facilitate participation in community life and activities.

The disability support services that are most appropriately provided by the NGO sector include supported residential services, advocacy, outreach programs, education and information services, vocational training and supportive employment, social and drop-in services, and consumer networks and respite care⁴¹. The role of consumers in developing supportive leisure and social activities needs also to be recognised.

Outreach programs are less frequently provided by NGO community-based services across NSW. However, these services have the potential, and should be supported, to provide some of the most practical assistance with clear outcomes, including community capacity building, peer support and volunteering.

Future directions: the need for partnerships

Clinical rehabilitation and disability support are not mutually exclusive concepts – services are often provided concurrently. Partnerships between clinical rehabilitation and disability support services will need to be operationalised at the local level. This may involve agreements or memoranda of understandings that clarify and define the responsibilities of each sector in the transition phase when consumers move between two separate services, and when both sectors remain involved in providing services.

As part of the implementation of the *NGOs and Mental Health: A Framework for Partnership*, a review of disability-support-related mental health services will be undertaken, to identify the specific Area-based programs that would be best managed by NGOs. The development of a process, framework and plan by Areas, in partnership with NGOs, for the staged evolution of identified services to NGOs will be a key strategy within this review.

Arguably, the most important vehicle for service delivery is that of empowering consumers and enhancing their ability to manage wellness as well as illness. For further information about empowerment and building personal strengths, including the need to promote consumer participation and ownership in the rehabilitation process, please refer to page 13.⁴²

3 New focus for planning and delivering rehabilitation programs

Mental health is not simply the absence of mental illness; the term describes the capacity of individuals and groups to interact with one another and their environments in ways that promote subjective wellbeing, optimal development and the use of mental abilities – cognitive, affective and relational abilities⁴⁴.

This framework presents a guide to rehabilitation for mental health that integrates mental health promotion, prevention and early intervention, for a range of mental health problems, with treatment and continuing care within a population health model.

Collaborative partnerships are essential for the development and implementation of initiatives and services that incorporate mental health promotion, prevention and early intervention. For example, many people with a mental illness will present to a range of other services, such as general practitioners, private psychiatrists and school counsellors, prior to referral to a mental health service. Establishing collaborative links with these services will facilitate early identification, and active support of functioning from this earliest stage.

Mental health promotion

Mental health promotion is any action that is taken to maximise mental health and wellbeing among populations and individuals, including people with a mental illness. It aims to protect, support and sustain the emotional and social wellbeing of the population by promoting the factors that enhance mental health⁴⁵. Mental health promotion focuses on identifying and implementing strategies to enhance the capacities and strengths of individuals by promoting resilience in the face of adversity, thus reducing the likelihood of disorders.

‘Progressive Employment Personnel (PEP) is a supportive employment agency which assists people who have a psychiatric disability to choose, attain and maintain open employment. PEP is funded by the Commonwealth Department of Family and Community Services and has been successful in assisting people with a psychiatric disability into open employment since 1994’.

Mental Health Coordinating Council, 2001

Examples of mental health promotion strategies that may be integrated within rehabilitation services include:

- identifying the strengths of the individual with a mental illness, and ways to optimise these strengths can be optimised, such as promoting positive self image, encouraging a sense of hope for the future, and facilitating supportive networks
- strengthening the family capacity to care for individuals who need support
- promoting awareness and acceptance of mental illness to reduce stigma associated with mental illness
- facilitating supportive networks for people with a mental illness, with local services such as local sporting and recreational facilities, workplaces and others
- capacity building in the broader community.

Prevention

Prevention is defined as ‘interventions that occur before the initial onset of the disorder’⁴⁶; it should focus on families to prevent, when possible, the development of these illnesses or other mental health problems. For example, establishing programs for children with parents with a mental illness should be a significant component of service planning. Prevention may also focus on assisting people with a mental illness to deal with stressors and adversity, so as to lessen the risk of comorbidity that may otherwise occur (ie depression).

Early intervention

Early intervention is the early identification of emerging signs and symptoms of mental health problems and disorders to enable timely, effective and appropriate treatment that can prevent diagnosable illness and reduce the disability associated with symptoms⁴⁷. This includes the aim of providing the earliest possible treatment and necessary rehabilitation and support services to prevent relapse or the recurrence of symptoms, and to maintain optimal functioning to promote recovery. Facilitating early intervention often involves enhancement of partnerships with other services and agencies that are likely to be in contact with individuals in their early stages of a mental illness. This process encourages the establishment of identified pathways to care with clear roles and responsibilities for the agencies involved.

For example, a key outcome of the School-Link initiative is to foster links between the mental health and education sectors, to encourage the early identification and management of mental health problems and disorders, particularly depression, with adolescents in high schools. The *Getting in Early* framework document discusses these issues further⁴⁸ – the focus is on supporting functioning in the school settings and the home.

In the context of rehabilitation, early intervention may require new and different rehabilitation strategies from those that are used routinely for people with longer-term mental illnesses. New and emerging models for rehabilitation are becoming available for people with early psychosis.

‘The South Eastern Sydney Area Health Service Strategic Plan for Mental Health Rehabilitation Services sets out a comprehensive structure for the coordinated planning, delivery and evaluation of mental health rehabilitation in the Area Mental Health Program. It contains the elements for the redevelopment of rehabilitation services across the Area in order for services to be appropriate, effective and efficient’.

South Eastern Sydney Area Health Service, 1999

Developing rehabilitation services: meeting the needs of the whole community

Rehabilitation Development Groups in each Area Health Service

An essential component of the *Framework for Rehabilitation for Mental Health* is an appropriate structure to develop, monitor and manage the quality of rehabilitation for mental health services that are being delivered in an Area Health Service.

The recommended structure is a Rehabilitation Development Group (RDG), in which the various clinical and corporate governance structures in the Area Health Service will inform and support the purpose and function of this forum. Membership would consist of consumers and carers, multidisciplinary representation from Area Health Service staff, NGOs⁴⁹, GPs, other government departments and private sector representatives. An identified chairperson would coordinate the group, which would report to the Area Director for Mental Health, in accordance with the suggested committee structure (see Appendix B)⁵⁰.

3

The purpose of establishing RDGs is to provide a means by which the quality, outcomes and skills for rehabilitation provided to consumers within that Area can be developed and defined, measured, monitored, improved and reported. Reports should be made available to service recipients, clinicians and managers of the Mental Health Services, the Area Health Service Executive, NSW Department of Health.

The various skills and resource bases in the Areas and the different capacities to develop rehabilitation programs, including the opportunity to involve a range of clinicians such as general practitioners, will be a key consideration during the planning of activities by this forum.

Each RDG should develop objectives for work in accordance with the format outlined in Appendix B. This includes the need of these groups to negotiate access to rehabilitation services across Area Health Service boundaries collaboratively. The RDG needs to ensure that services and service planning will take into consideration a diverse range of support requirements to meet the rehabilitation needs of clients with mild, moderate or severe problems.

RDGs will be uniquely placed to promote and lobby for the local implementation and funding of a population health model for mental health rehabilitation, consistent with such service models developed under the National Mental Health Strategy and related NSW initiatives⁵¹. In particular, this approach will strengthen further the role of NGOs as affiliated service providers.

Another key feature of the RDGs will be their ability to identify available rehabilitation and disability support services to other local health care providers. One example is the Divisions of General Practice and how GPs can access rehabilitation and disability support services. The continuous involvement of private psychiatrists, including established and formalised links with this important source of expertise and referral, will also assist to improve communication, access to, and knowledge about these services (Actions 1 & 2).

The role of assessment

It is essential that any plan for mental health rehabilitation be integrated with overall mental health care for individuals. The process of rehabilitation begins with a comprehensive assessment. Every person who enters the mental health system for more than a brief single response or intervention will be provided with a comprehensive assessment covering all aspects of their general and mental health, and their rehabilitation needs. Assessment is a core component of the rehabilitation framework, and it is a joint responsibility of clinical services, support services, the individuals who need support and their carers.

Such assessments or their components currently are carried out routinely in mental health services. However, the existing assessment process will be developed to incorporate a 'strengths based' approach – the assessment of functional and quality of life issues – rather than focusing solely on deficits and symptoms. This will facilitate the development of plans that will achieve optimal outcomes for individuals. Furthermore, an emphasis on collaborative therapeutic relationships and an individual-centred assessment process will ensure acknowledgment of each person's identification of problems that have most impact on their life, and subsequently may be incorporated as key items in the management plan.

'MH-OAT is a statewide project which seeks to strengthen the mental health assessment skills of clinical staff in mental health. The project will coordinate the implementation of mental health assessment training, uniform assessment protocols and outcomes and casemix measures throughout NSW'.

MH-OAT, NSW Department of Health, February 2001

The assessment process should not become burdensome for the consumer and should have the capacity to be delivered in modules. It is intended that the same package be used regardless of the point at which individuals who needs support enter the system, and that the package will ensure integrated assessment of impairment, disability, adaptive functioning and participation. Assessment provides the basis on which an individual care plan can be developed. The process of assessment is being developed further and standardised as part of the Mental Health Outcomes Assessment and Training Project (MH-OAT). A specific assessment process for children and adolescents will be included.

Information systems and technology structures

Information technology infrastructure, including individual tracking infrastructures, to facilitate reliable documentation and transfer of information between service providers and consumers, will be available as part of the implementation of the Mental Health Information Development Project. This project will play a significant role in promoting easy access to relevant, timely, and comprehensive databases of information. The implementation of this important project is a further requirement for measuring successful health outcomes and the performance of services, and for judging the impact of policy change in the delivery of rehabilitation for mental health.

Community-based classification systems for information will link health care resources effectively to the needs of the community, and categorise mental health rehabilitation services that are provided to people with similar mental health needs and who use approximately the same level of resources. The issues of privacy and informed consent, as well as the need to integrate communication and interfaces between existing and planned information systems, are currently being addressed by NSW Health (Action 3).

The importance of continuity of care

Each person will have a care plan that identifies strategies to enhance strengths and capacities as well as specific interventions to address or prevent areas of disability and impairment. Family and carer needs for support, skills building and information sharing need to be considered, particularly for children and adolescents. Education and employment issues, accommodation support, social relationships and leisure also need to be considered.

'The Active Linking Initiative: Boarding House Reform Strategy offers a variety of community-based recreation/leisure, educational and training activities to approximately 1600 people with disabilities residing in licensed boarding houses across NSW. This is one component of a recent Government initiative to improve the quality of life of people with disabilities living in licensed boarding houses.'

*NSW Department of Ageing,
Disability and Home Care, 2000*

The plan will identify services providers that will take responsibility for each aspect of care. For example, an accommodation support service to provide skills training and improve role functioning in the home setting, and a GP to provide or coordinate clinical aspects of care. Area Health Services will monitor the needs of consumers, and will negotiate with the disability and housing sectors to ensure that adequate and appropriate support is available to those with high support needs.

3

The tracking, monitoring and reviewing of the passage through the health system of a large number of people who need support requires that there be an identified health care provider responsible in each case. This provider may be the GP, a community mental health nurse, a private psychiatrist, or some other mental health professional or service provider (such as a NGO), as dictated by discharge and follow-up arrangements. The overall plan and rehabilitation package will be reviewed every three months and the frequency of medical or other specific consultations or reviews (including exit strategies) will be identified clearly in the plan.

The plan is to be developed in collaboration with the person and will express the person's goals for recovery. It will incorporate written indicators of progress as well as an expected time line. The recommended framework moves well beyond the provision of rehabilitation services at inpatient and community mental health facilities – each person may engage in several rehabilitation processes or activities across various settings, with as much emphasis as possible on mainstream services.

This initiative will require that new relationships be forged with community agencies and may include such activities as encouraging a sponsoring relationship with a sporting facility, or providing support and skills building to a provider of educational or recreational services so that the provider can facilitate the people's integration into the community.

Access to community resources, including housing and accommodation support services, is a key requirement for the provision of comprehensive rehabilitation for mental health. A strategic framework that seeks to address the issue of housing and accommodation support services – a related initiative – is currently being developed. The Rehabilitation Development Group in each Area will oversee the establishment and maintenance of these key processes, to promote coordinated and continuing community-based care, including hospital admissions when necessary. These groups will identify all relevant services and agencies in their areas and seek to expand the scope of possible linkages with the aim of integrating the recovery process with the mainstream community.

Rehabilitation packages: an emerging classification system for interventions

The need for standardised practices

NSW Health faces a difficult task of responding to both the increasing demand for public health services and widening community expectation for high quality care, within a specific budget and an evidence-based framework⁵². This is a key issue within the *NSW Government Action Plan*, which seeks to shift the focus of clinical management to output, outcomes and quality.

The concept of 'rehabilitation packages' is important for ensuring that practices become standardised, and for the development of clear directions for the scope and standard of rehabilitation interventions. The concept introduces an effective system of time-limited and performance-based rehabilitation interventions that incorporates the notion of 'best practice'.

Defining 'rehabilitation packages'

The term rehabilitation package is used to describe a range of both clinical rehabilitation and disability support interventions that relate to recovery from a mental disorder. Each package includes a range of 'phases' on a continuum, commencing with access and entry into the service, and may be provided in both community and hospital settings.

The rehabilitation package may include both clinical rehabilitation and disability support interventions. The primary goal of the clinical rehabilitation package components is improvement in functional status, skill development and wellbeing. Interventions that relate to clinical rehabilitation are time-limited and involve individual assessment and review at agreed intervals. The goal of disability support is the maintenance of functional status and skills, and the duration of interventions may be longer than interventions clinical rehabilitation.

The profile of rehabilitation packages

Generally, the rehabilitation package will have the following components:

- Individualised, baseline and periodical multidisciplinary assessments of functional ability, using a recognised functional assessment measure.
- An individualised rehabilitation plan that includes mutually negotiated rehabilitation goals and indicative time frames. The individual will work with the members of the multidisciplinary team to develop this plan.
- Clinical rehabilitation and disability support, ie evidence-based clinical interventions and planning for discharge, and, potentially, community living and accommodation support. The following elements may be involved:
 - skill building to enhance social competence in areas such as structuring time, communication, shopping and household tasks
 - support for self-care and maintenance of physical health, and the promotion of awareness of what is required to look after one's health – both to respond to risks to health and to prevent ill-health – including seeking professional assistance in looking after one's health, following medical and other health advice, and avoiding risks to health such as physical injury
 - education about transmissible diseases, drug taking, and sexually transmitted diseases
 - assistance to find, keep and maintain open employment, which may include vocational training activities that are related to actual work experiences
 - provision of educational opportunities, particularly for young people as a prerequisite to a productive life (includes options such as high schools, vocational and business schools, community colleges and universities)
 - cognitive-focused interventions such as cognitive behavioural therapy, direct remediation and cognitive adaptation training
 - enhancement of access to pleasant, affordable and appropriate housing

- advocacy for and establishment of links to social and leisure programs to improve quality of life.

- Documentation of the process.

‘Many complex and ongoing health problems, such as mental health problems, can be managed with timely and effective treatment in an outpatient setting, thereby preventing and/or reducing hospital admissions’.

*NSW Government Action Plan for Health:
Improving Health Care for People with Chronic
and Complex Health Conditions*

Each rehabilitation package may include episodes of care, defined as a continuous period of contact between an individual and a provider or team of providers. Each package should be provided continuously across the range of settings, including acute inpatient, non-acute inpatient, and community (ambulatory and residential). It is important to spell out for each care episode the interventions that are likely to be effective, and a timeframe for review (Action 4).

The importance of benchmarking

Benchmarking is a process for finding, adapting, and applying best practices. It involves learning from other people's experience and measuring services and clinical practices against other service providers in the field of rehabilitation. The notion of benchmarking should be considered by those involved in providing rehabilitation programs and individual packages.

Clinicians and managers will be encouraged to identify variations in cost and practices so these can be managed at the local level in the context of improving the efficiency and effectiveness of rehabilitation services. Such activities provide the mechanisms to reward good practice and support quality initiatives.

3 Supporting young people

Young people's mental health is as important to their development as their physical health. Mental disorders such as depression, psychosis and comorbid disorders, impact greatly on young people, their families and social networks⁵³. These disorders affect the young person's biological capacity to mature and accomplish developmental tasks, especially those relating to social development and independence. They may impact upon thinking processes, emotions, perceptions, motivation and confidence, and lead to difficulties in learning, problem solving and achieving vocational goals.

The pathways to effective mental health rehabilitation for young people provide opportunities for early recognition, intervention and referral. These pathways should include the use of rehabilitation packages that are to be developed in partnerships with education providers, and should target their schooling and other education, employment, the ability to cope with life situations and transitions, relationships and the capacity to enjoy everyday activity.

It is recommended that Rehabilitation Development Groups undertake detailed service planning to respond to the rehabilitation needs of young people. This includes establishing collaborative partnerships with other relevant programs for young people, such as early psychosis programs, School-Link initiatives, relevant youth health services and NGO programs.

Models for intervention in early psychosis

Early intervention has been shown to improve outcomes significantly for young people with early psychosis and their families. Effective early intervention for early psychosis can also result in more rapid and complete recovery, lower risk of relapse and suicide, less treatment resistance, fewer hospital admissions and less disruption to social, functional and familial roles⁵⁴.

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

Psycho-education that focuses on early psychosis, for consumers and their carers, can contribute to better adaptation and a reduction in relapse of consumers with a psychotic illness⁵⁵. Also, there is growing evidence to support the role of cognitive interventions in early psychosis⁵⁶. The apparent benefits of group work and other rehabilitation interventions such as interventions that address issues of comorbidity, especially cannabis use, are being investigated further. The early psychosis programs that have been established across NSW provide effective rehabilitation.

'Evidence increasingly shows that preventing and intervening early for young people with mental health problems, particularly depression and first onset psychosis, can dramatically improve immediate and long term outcomes'.

NSW Health: Getting In Early, A Framework for Early Intervention and Prevention in Mental Health for Young People in NSW, November 2000

Equity and access for rehabilitation

Support for the people who are most disadvantaged is an important part of the framework. The following population groups require additional support:

- People with complex and chronic disorders, and often comorbidity, whose life trajectory has been progressively negative (e.g. people who are homeless or living in refuges).
- Indigenous people for whom disadvantage and mental illness may mean that existent programs are neither targeted nor culturally appropriate. Programs will need to be developed in consultation with indigenous communities to meet their specific needs. High levels of unemployment, isolation and lack of information may make the delivery of appropriate rehabilitation problematic but it is essential that each Area Health Service develops appropriate programs.
- People with chronic, severe and very disabling mental illness.

The need to explore structured work activities and social programs that can maintain or improve current ability to function, and improve quality of life for people who are unable to work in competitive employment due to the severity and enduring nature of their cognitive and functional impairments, is generally acknowledged. It is important to consider the needs of these people during service planning and delivery, and it is a key responsibility of the Rehabilitation Development Groups.

A range of centre-based and home-based services should be available to address the needs of these disadvantaged people. Voluntary agencies have an essential role in the provision of support and consultative advice, and the providers of rehabilitation and disability support services should work through the existing points of engagement – hostels, boarding houses and outreach programs. In dealing with people who require access to specific or supported employment programs, service providers, and their services must reflect, the principles of social justice and equity in the conditions of employment.

Some psychosocial self-help programs will address the needs of the most severely disabled consumers, including older people with long-standing mental illnesses, to facilitate the potential to be productive in settings that do not necessarily involve competitive employment. Two examples of these programs are ‘clubhouses’ and ‘living skills centres’. The aim of the framework is to ensure that such programs focus on specific needs, and that their stated goals relate to quality of life, meaningful and productive activities, and the monitoring of programs for each person.

Workforce development

The provision of high quality mental health rehabilitation services depends on the quality, skills and commitment of the staff who are involved from the public, private and NGO sectors. Their sense of mission and purpose, their knowledge, skills and attitudes are at the core of service provision. They are the primary resources and their contributions rely on education and training, support programs and staff recognition, research to inform their programs and work, and quality and review mechanisms to improve service provision⁵⁷. Collaborative research in partnership with higher education institutions will be a significant aspect of workforce development.

The strategies that are required for the development of an adequate workforce response to rehabilitation for mental health extend well beyond the narrow traditional notion of ‘training’. Systemic and sustainable changes within rehabilitation settings are essential. A shift is needed away from an exclusive orientation towards training to one that encapsulates organisational development, change management, evidence-based knowledge transfer and skill development.

'The Hunter Institute of Mental Health has been funded to produce a multimedia training and reference resource in mental health rehabilitation.

This evidence based training resource will be developed and produced in CD-ROM format for use by mental health professionals in the delivery of mental health services. It will offer details of methods, techniques, ideas and rehabilitation programs for use in mental health rehabilitation settings.'

*Hunter Institute of Mental Health, 2001
NSW Government Action Plan for Health:
Improving Health Care for People with
Chronic and Complex Health Conditions*

Multidisciplinary skills and competencies

The multidisciplinary workforce that delivers mental health rehabilitation programs is composed of psychiatrists and registrars, medical officers, nursing staff, psychologists or clinical psychologists, social workers and occupational therapists. The different expertise of each discipline contributes to the provision of rehabilitation programs and interventions. The ongoing involvement of medical staff beyond the acute episode includes assessment of factors that influence functions, such as continuing assessment of illness, cognitive functioning and medication management, and the monitoring of pharmacological side effects.

The providers of rehabilitation for mental health need an appropriate educational and professional background to ensure that they develop the necessary skills in:

- analysing and advising on each person's role functions in the community
- strength and capacity assessment
- targeted clinical intervention and disability support.

Skills in interpersonal engagement, overcoming resistance to change and promoting an individually focused but challenging environment are all essential elements for the provision of effective rehabilitation for mental health. A multidisciplinary team of health professionals is most likely to have this combination of skills⁵⁸.

Further professional development

Targeted continuing education is believed to add value to mental health treatment and care, and to be a fundamental component of professional development. Considerations for the development of educational programs include current staff knowledge and skill bases, and the need for building confidence and positive attitudes, which is consistent with program developments in other disability fields.

Staff in specialist mental health services and NGOs, as well as consumers and carers, need to be supported to attend appropriate education sessions and to extend both their formal and informal education⁵⁹. An important aim of this education should be to build awareness in the areas of appropriate rehabilitation philosophy and policy directions, as described in this framework.

The communication of a rehabilitation philosophy across all relevant areas of specialist mental health service delivery, which would include exploring the issues that limit participation in employment programs for people with a mental illness (eg schizophrenia), should be a key element of professional development programs. This shared philosophy will help to reduce stigma and maximise opportunities for these consumers.

Clinical competence is the responsibility of both individual clinicians and organisations.

Organisations must ensure that the infrastructure is in place to promote ongoing professional development as part of a quality framework for all clinicians. Links should be established with university faculties which are responsible for under-graduate curricula in the health disciplines to ensure that courses include knowledge about the scientific basis and skills required for effective rehabilitation, and, therefore, that new mental health graduates are competent in these areas.

Education in assessment, formulation, diagnosis, counselling, vocational rehabilitation, medical and social aspects of disability, mental health rehabilitation for people across the lifespan (including special population groups), as well as outcome monitoring, is a key component of continuing education for clinicians.

Written guidelines are an important component, as are the information systems that contribute to a readily accessible and up-to-date knowledge base. The principal challenge is to deliver effective education that provides for appropriate workforce capacity to achieve the goal of prevention (or reduction) of disability.

Supervision and consultation

Supervision and consultation are fundamental concepts that underpin the provision of quality rehabilitation services. Organisations need to consider the availability and appropriateness of resources to facilitate access to supervision and, or, consultation for both clinicians and clinical managers⁶⁰. Models for clinical supervision need to be flexible and should consider both the professional background and developmental needs of clinicians and the ongoing quality improvement aspects of their rehabilitation services. Appropriate consultation should be available readily to providers, consumers, carers and NGOs (Action 5).

Community development and partnerships in service delivery

Community involvement, engagement, empowerment, ownership and self determination are widely acknowledged as key principles that underlie community development approaches to the advancement of mental health and wellbeing⁶¹.

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

'Community participation is an integral component in policy development, health service planning, and quality improvement across NSW Health'

NSW Government Action Plan for Health: Improving Strategic Directions for Health: 2000-2005

This commitment may involve sponsorships from sport and fitness organisations, clubs, and employment opportunities with local business.

The need to encourage or assist consumers to use existing community (mainstream) resources maximally, and not remain exclusively in the mental health domain, is highlighted throughout the literature. The increasing use of community resources is seen as a natural part of the improvement in a person's functioning and an aid to integration within the community⁶².

Supporting consumers to become a part of their communities is an important goal. This support should occur at the level of individual intervention rather than larger initiative (e.g. groups of consumers accessing a sporting facility). Developing relationships so that consumers truly are part of a community requires an individual approach, to prevent the perception that consumers belong to an identifiable, stigmatised group that uses community-based resources. The support that consumers offer to one another also needs to be recognised as a significant contribution to rehabilitation for mental health.

Community partnerships

Working together to improve services and opportunities for consumers and their carers is not a new concept. In order to provide integrated services and opportunities for people to participate fully in the community, government and community agencies must work together regardless of traditional organisational boundaries. Partnerships lead to better-integrated services⁶³.

3

The development of partnerships in service reform and delivery is defined by current state and Commonwealth public mental health policies as a key strategic direction. NGOs and community support services, including mainstream and specialist services, provide disability support and other support programs that are essential for the improvement the quality of life for people with mental illness and psychiatric disability⁶⁴.

Effective mental health rehabilitation services and relevant services that are provided by community agencies will be available to work collaboratively to provide services. Local mechanisms should be established at the Area Health Service level to facilitate collaborative working relationships between mental health rehabilitation services and community agencies, including local business and government agencies.

Consumer partnerships

The importance of consumer participation in the planning, implementation and evaluation of mental health services is a key aspect of current reform in Australian health care⁶⁵. Unless individual consumers are involved in decision-making, then the objectives of the framework that are essential for up-to-date provision of mental health rehabilitation may be misunderstood or, potentially, rejected.

The current organisational structures for consumer participation and involvement in rehabilitation service planning and delivery will also need to be assessed, to ensure that effective systems are, or can be put, in place. Consumer partnerships should exist in all communities at the levels of treatment and care, recovery, service system (mental health service, NGOs and community support services), and consumer driven services⁶⁶. Consumer partnerships are also important in the context of mental health promotion, prevention and early intervention (refer to 'Rehabilitation for health: best available evidence' pages 11-13).

'The GP-Link Project in Northern Sydney Area Health Service is funded under the Second National Mental Health Plan, and aims to further the links between mental health services and GPs in Northern Sydney Health. The project aims to increase communication and collaboration between Services and GPs, and examine the structures and systems within the mental health services so that they and GPs can work together more effectively'.

Northern Sydney Area Health Service, February 2001

Family and carer partnerships

A carer is someone who provides care and support for a parent, partner, child, relative or friend who has chronic mental illness or related disability. Carers make a significant contribution to the community and to the quality of life of the people they care for. The NSW Government, policy makers and health care providers believe that the needs of carers should be understood and supported⁶⁷.

This support may involve improving existing support services, informing people of available services, developing new supports for carers, and providing educational opportunities for families. The framework also seeks to encourage debate about, and innovative strategies for, promoting broader community support for carers and the people who receive care.

Partnerships with general practitioners and private psychiatrists

During the process of rehabilitation, the emphasis on self-care becomes stronger for the maintenance of both physical and mental health care. It is important for each person's GP to be included in the planning of rehabilitation, and for a clear plan of care to outline who will be providing each part of a rehabilitation package. An informed GP can provide support for the patient, family and other carers during rehabilitation. The GP provides physical health care that includes routine prevention and treatment services, and may also be involved in significant aspects of mental health care, including the provision of medication. Some GPs may also provide brief, targeted psychological interventions.

Some consumers will continue to consult a private psychiatrist during the process of rehabilitation. As with the GP, it is important to delineate the role of the private psychiatrist in the overall rehabilitative plan and to communicate this information clearly. In some instances, the psychiatrist will coordinate rehabilitation, and in others, more commonly, the psychiatrist will be a member of a rehabilitation team. The psychiatrist may prescribe and monitor treatment, including the provision of medication for individuals with complex problems, provide support for the rehabilitation process, and provide psychological interventions that enhance the rehabilitation process.

Partnerships with drug and alcohol services

Access to rehabilitation programs for people with comorbid mental health and substance use disorders is an important area of need. Access is required to short and medium-term rehabilitation programs, and more intensive programs for people with severe co-morbid conditions and for whom other treatment options may not be effective or appropriate⁶⁸.

Rehabilitation may be community-based, residential or part of a more broadly based supported accommodation program. Programs should be flexible, personalised and based on the best available evidence⁶⁹.

Strategic Action Checklist

Action 1

Rehabilitation Development Groups will be established in each Area Health Service.

Action 2

Service plans for rehabilitation and disability support programs, consistent with policy directions, will be developed.

Action 3

Clinical rehabilitation services will participate in information development and activity data collection, within existing and planned IT initiatives.

Action 4

Individually targeted 'rehabilitation packages' for a range of needs will be available in each Mental Health Service.

Action 5

Self directed learning packages will be provided to support workforce development for staff in clinical rehabilitation and disability support services.

Action 6

Clinical rehabilitation and disability support services will participate in existing and planned quality and review activities.

4

Mental health settings throughout NSW are in the midst of significant change. New policy directions about what constitutes ‘best practice’ in the provision of mental health care have been prepared through such initiatives as the Second National Mental Health Plan, the Population Health Model for the Provision of Mental Health Care, and the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health and the accompanying monograph.

Community mental health treatment and support services, including those that are provided by GPs, are now the primary focus of care for people with mental health problems throughout the 19 Area Health Services of NSW. The traditional provision of mental health services – methods of designing and delivering services, mechanisms for establishing and funding service priorities, accountability and reporting structures, staff roles and competencies, and requirements for education and training – is undergoing scrutiny and change. An important part of this change is the recognition of the vital role that consumers and carers have in governance, policy formulation, service planning and delivery.

Increasingly, such trends are shaping future directions for rehabilitation for mental health, and should be considered together with new evidence and greater knowledge about best practice, that are obtained from research, clinical practice, consumers and carers.

Rehabilitation for mental health: new evidence and policy directions

Historically, rehabilitation services have been arranged in various ways, including the more traditional facility-based programs that may be found in communities and specialist psychiatric hospitals throughout NSW, and, more recently, community-based services that support the ways in which people in a community typically live, work and relax.

There is evidence from research to support the following changes to directions for public policy and mental health.

- A service management system that incorporates well defined critical pathways between clinical rehabilitation and disability support promotes value for money and the effective use of staff competencies and skills.
- A focus on mobilising wellness, in contrast to a focus on the severity of disability, will likely result in better health status and quality of life, improved symptom stabilisation, and an overall decrease in welfare and health care costs.
- The provision of interventions that lead to re-entry of people into open or competitive employment, including supported employment interventions, will ensure better outcomes for each person.
- Skills that are acquired in a structured, artificial environment are not readily transferable to the outside world⁷⁰.

'NSW Health is currently implementing substantial, comprehensive improvements right across our state's public health system. Teams of clinicians, managers and consumers are leading this unique and challenging process, which is firmly based in principles of clinical improvement'.

NSW Government Action Plan for Health

This framework was prepared to provide directions for the planning and delivery of rehabilitation in NSW mental health services. It is a guide to change management that promotes skill and environmental development, to help people who need rehabilitation to:

1. capitalise on their personal strengths
2. develop effective coping strategies
3. develop supportive environments so that they may function more independently.

Quality framework

The *Framework for Managing the Quality of Health Services in NSW*¹ introduces six performance dimensions of quality as a basis for measurement, reporting and improvement efforts: safety, effectiveness, appropriateness, consumer participation, access and efficiency. The *Framework for Rehabilitation for Mental Health* is consistent with this policy initiative, and can be applied to each dimension as follows:

- **Safety**

The framework facilitates evidence-based and safe practice, improved data collection is encouraged through information initiatives and it allows for the investigation of incidents and events.

- **Effectiveness**

Measurement of the effectiveness of rehabilitation interventions, through the use of process evaluation and outcomes measurement, will demonstrate the extent to which the desired mental health outcomes have been achieved.

- **Appropriateness**

The framework recommends that interventions be performed according to agreed, evidence-based indications, tailored to needs as assessed for the individual consumer, and in a timely manner.

- **Consumer participation**

Partnerships with consumers and carers are advocated as a basis for planning, implementation and evaluation of mental health rehabilitation services.

- **Access**

A key feature of the framework is to ensure access to rehabilitation for people with a range of disorders, including groups of people with special needs, people of linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people, and people who live in rural and remote areas.

- **Efficiency**

The use of economic evaluation to ensure cost effective service delivery, and the overall objective of reducing disability through emphasis on vocational rehabilitation and other effective strategies, will contribute to improved efficiency in the provision of rehabilitation services.

Expected benefits

5

Direct benefits are expected to be associated with policy development for rehabilitation for mental health:

- integrated, wellness-focused rehabilitation services for the whole of the community
- improved outcomes for people with mental health problems and disorders
- identification of an efficient infrastructure upon which to deliver mental health rehabilitation services to meet a range of population needs, within a framework for quality and cost effectiveness
- specific rehabilitation packages that cover a range of mental health problems and disorders, and to ensure these can be targeted to the assessment of individual need
- access to rehabilitation for population groups with special needs, including people of indigenous and culturally and linguistically diverse backgrounds, people with co-morbidity problems, and people who live in rural and remote areas
- a set of guiding principles developed and adapted by all stakeholders to guide service delivery
- clear roles and expectations of all service providers, including a clear distinction between clinical rehabilitation and disability support, and the important contribution by NGOs

'The new computerised Supervisory Audit Tool allows team leaders in Southern Area Mental Health Service to benchmark and to ensure uniformity of best practice quality care delivery to all individuals, including rehabilitation services.'

Southern Area Health Service, January 2001

- defined positive individual health and service outcomes that reflect the guiding principles and promote accountability
- genuine and active participation by consumers, their carers, families (particularly for children and adolescents), service providers, and policy makers in the planning, implementation and evaluation of rehabilitation programs
- identification of best practice, including alignment between the skill base of staff and clinical needs of individuals – a commitment to focus resources on establishing and supporting a range of meaningful employment, education and vocational options
- an undertaking to address the stigma and discrimination associated with mental disorder.

How will we know it worked?

People who need mental health rehabilitation, their carers, families, policy makers, clinicians and managers, have an interest in the quality of care that services provide. Several studies have drawn attention both to the recent progress made in system-wide quality improvement for rehabilitation services and the need for concerted effort to improve quality of care further⁷².

Measuring quality and effectiveness is fundamental to the provision of rehabilitation for mental health in which the key elements for achieving best practice are fully integrated.

Currently, the reviewing and monitoring of mental health service quality is reflected in systems such as clinical peer review, inspections of mental health facilities under the *Mental Health Act 1990* (NSW), accreditation and standards schemes, the Official Visitors Program, and mechanisms for complaints, critical incidents handling and resolution. Rehabilitation programs are also subject to these review mechanisms.

The *Framework for Managing the Quality of Health Services in NSW*⁷³ provides a basis for comprehensive performance management across several aspects of service provision. The development of indicators that are relevant to mental health and collected within each of the six performance domains will ensure that there will be a broad and comprehensive assessment of organisational output and consumer outcomes (refer page 28 for further information).

The linking of all of these quality improvement activities to the provision of rehabilitation is essential to ensure the successful implementation of the *Framework for Rehabilitation for Mental Health*. In the consideration of the role of transparent performance evaluation of mental health rehabilitation services, it is useful to consider three perspectives from which quality can be assessed – inputs, processes and outcomes⁷⁴.

Inputs

Quality can be measured by reviewing the inputs of mental health rehabilitation services. Input indicators describe the resources, such as funding, materials, and staffing arrangements, that go into the system.

The role of economic evaluation in promoting cost effectiveness within a quality framework of best health outcomes must be emphasised. Increasingly, NSW Mental Health Services are being made accountable for directing funding towards rehabilitation programs that demonstrate effectiveness and efficiency. Therefore, this framework advocates the use of formalised economic evaluation tools, such as cost-effectiveness, cost-utility and cost-benefit analysis. Generally, economic evaluations should be included in the measurement of the impact of rehabilitation programs, in the interest of providing economic as well as clinical evidence about the interventions⁷⁵.

Processes

Quality can also be measured by reviewing the processes that are involved in the delivery of mental health rehabilitation services. This review would include the activities of the service, measured in terms of procedures, practices and activities, and the people who receive such services.

Processes include reference to measuring activity levels (including benchmarking), undertaking consumer satisfaction surveys, and a variety of local audits and internal service reviews, and the degree to which they meet policy requirements for accountability and practice. Consumer, carer and NGO involvement in surveys will significantly strengthen the value of the quality improvement audits.

Process evaluation investigates the process of delivering the mental health rehabilitation programs, including alternative modes of service provision. Several audit tools and systems are available, including those already in place within NSW Mental Health Services.

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6 Outcomes

Quality and effectiveness can be measured further by assessing outcomes – changes that result from the care that is delivered. Outcomes include direct measures of individual health status, or system-wide measures at the population level. Measurement scales that assess health outcomes on various dimensions of ability, role functioning and participation are feasible for use in mental health rehabilitation services⁷⁶. The identification of measures that are applicable, acceptable and practical, valid, reliable and sensitive to change for each individual's recovery and in the rehabilitation setting, is a key aspect of the role of the Rehabilitation Development Groups.

The need for development of health outcomes measures that focus on personal strengths, role function and quality of life, is acknowledged within the framework. However, the available approaches that may be potentially useful for the routine measurement of outcomes in mental health rehabilitation settings include the Hunter Opinions and Personal Expectations Scale (HOPES), the Role Functioning Scale (RFS), the Camberwell Assessment of Need (CAN) Scale, and the KESSLER (K) 10 to measure psychological distress.

Other approaches that may be potentially useful in terms of measuring health outcomes as related to the MH-OAT project include the Health of the Nation Outcomes Scale (HoNOS), HoNOS65, Life Skills Profile (LSP), and Resource Utilisation Groups – Activities of Daily Living (RUG-ADL)⁷⁷. The collection of these indicators is required by the Commonwealth Government under the current Australian Health Care Agreements. Area Health Service staff will be trained in the routine collection of these measures as a component of the MH-OAT project.

The following specific measures have been identified for inclusion in the mental health services for children and adolescents: the Health of the Nations Outcomes Scale for Children and Adolescents (HoNOS-CA), the Children Global Assessment Scale (CGAS), and the ICD10 Factors Influencing Health Status and Contact with Health Services (FIHS). The Strengths and Difficulties Questionnaire (SDQ) has been adapted and included. A specific module is being prepared that addresses outcome measures for young people (*Action 6*).

Implementation strategy

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The suggested implementation strategy is a broad structure and should be adapted, as required, to meet local Area needs and population health, without loss of the intention of each of the actions or final outcome of the implementation.

The Implementation strategy presented in Appendix D covers the planning, delivery and evaluation of mental health rehabilitation services in the following five areas:

1. **Organisational structures for governance and accountabilities** (Actions 1 & 2)

Mental health rehabilitation services will be coordinated and managed by Rehabilitation Development Groups. Memberships will be multidisciplinary, including medicine, nursing and allied health, non-government organisations, general practitioners, private psychiatrists and other government departments. Services will be delivered in partnerships with these groups.

2. **Data collection and information development** (Action 3)

Rehabilitation services will be linked to existing mental health information initiatives, such as the Mental Health – Outcomes Assessment Tool and the Mental Health Information Development Project.

3. **'Rehabilitation packages' for a range of mental health needs** (Action 4)

Rehabilitation packages that are goal-oriented and based on individual assessment will be provided, with the primary goal to improve functional status and skill development.

The following components will be included in the package:

- an individualised, baseline and periodic multidisciplinary assessment of functional ability, using a recognised functional assessment measure

- a rehabilitation plan that includes negotiated rehabilitation goals and indicative time frames
- clinical rehabilitation and disability support, including evidence-based clinical interventions and planning for discharge, and, potentially, community living and accommodation support (includes documentation).

4. **Workforce development** (Action 5)

The educational needs of the rehabilitation service and all multidisciplinary and affiliated staff, including non-government organisations, will be met through organisational and professional development programs. This includes the targeting of staff knowledge, skills and attitudes to ensure best practice, consistent with the *Framework for Rehabilitation for Mental Health*.

5. **Quality and review activities** (Action 6)

Rehabilitation services will be linked to existing and planned quality improvement initiatives. This includes participation in accreditation programs, the Official Visitors Program, Statutory Review under the *Mental Health Act 1990* (NSW), the Mental Health Review Tribunal, the reporting of critical mental health incidents, management of complaints and collection of indicators.

Next steps

8 It is hoped that this paper will stimulate debate within the rehabilitation services, the broader community of mental health providers and people who need access to services and their carers, in NSW. The major outcomes will be the identification of areas for service planning and the development of policies at the Area Health Service level. The paper provides a conceptual framework for considering good practices in the provision of mental health rehabilitation, and identifies key issues and questions to be addressed.

The service development template attached in Appendix C is intended specifically to provide directions for health services to better meet people's needs for rehabilitation for mental health, including how to design, develop and deliver effective interventions. An implementation strategy to inform local service implementation of the framework is attached in Appendix D.

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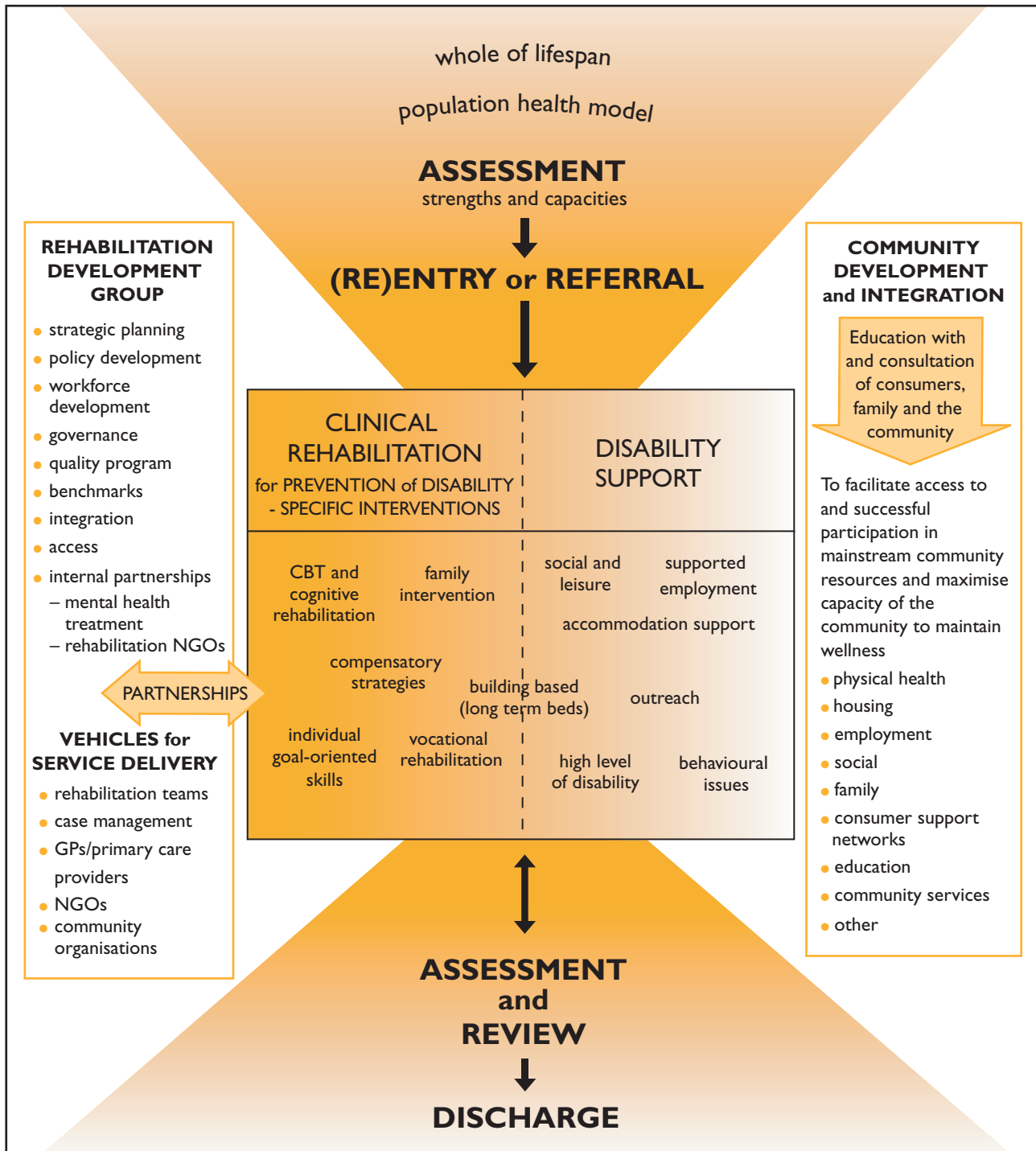
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Policy framework for the provision of rehabilitation for mental health



Appendix B

Rehabilitation Development Group

B Suggested membership, reporting structures and global objectives

Membership and reporting structures

- Membership consists of consumers and carers, representation from all disciplines that comprise the team (including medicine, nursing and allied health), non-government organisations, general practitioners and private sector representatives where appropriate.
- An identified Chairperson will coordinate the group which reports to the Area Director for Mental Health.

Global objective 1: Providing leadership

- To have effective mechanisms within the Area that give effect to the principles established by the *Framework for Rehabilitation for Mental Health*.
- To improve rehabilitation services continuously by supporting, guiding and cooperating with people within the services who can positively influence the directions of care.
- To provide advocacy for mental health rehabilitation services in each Area Health Service.
- To promote service integration and effective partnerships with all health care facilities involved in rehabilitation and disability support, both internal and external to the Area Health Service.
- To collaborate with mental health service managers in workforce planning, and education and training exercises.

- To ensure that rehabilitation is delivered in the most effective and efficient manner to achieve optimal outputs and outcomes, including appropriate role and function distinctions between clinical rehabilitation and disability support services.
- To build on the expertise of the community through education, provision of rehabilitation packages and supportive community programs.
- To ensure that rehabilitation is available and accessible for all consumers, particularly those with special needs.

Global objective 2: Promoting quality and benchmarking

- To engage in strategic planning and policy development for mental health rehabilitation.
- To have a reporting strategy to the Area Mental Health Service that provides current, useful information upon which to make key corporate decisions.
- To have in place an effective and comprehensive strategy for communicating with the public regarding the state of rehabilitation service provision and its implications.
- To be well placed to make improvements in the provision of rehabilitation for mental health, through benchmarking and quality improvement activities.
- To maximise the adoption of existing and future evidence-based practice guidelines for effective and appropriate psychiatric rehabilitation interventions.

Appendix C

Template for service development

Rehabilitation for mental health

Each Area Health Service will provide a recovery oriented, integrated rehabilitation service system grounded in the goals, needs and wants of consumers and family members, and, or, carers, which will help to guide the development, funding and evaluation of all clinical, disability/rehabilitation, and self-help/peer-support services.



Quality management domain	Performance measure (each Area Health Service)
Service planning	Mental health rehabilitation services are effectively and efficiently governed and managed by a Rehabilitation Development Group, where memberships are multidisciplinary and include representation from all members of the team (ie medicine, nursing and allied health), non-government organisations, general practitioners, private psychiatrists and other government departments. An identified chairperson coordinates this forum.
Rehabilitation interventions	<p>Access to a range of interventions is provided, including:</p> <ul style="list-style-type: none"> ● vocational rehabilitation programs, involving consumer goals of supported or competitive employment as appropriate ● social skills building, involving learning activities to meet interpersonal, self-care, home maintenance, education, vocation, leisure, social skills and coping demands of community living ● family psycho-education with joint involvement of consumers and their families ● cognitive focused therapies, including CBT, direct remediation and cognitive adaptation training.
Mental health promotion, prevention and early intervention	A commitment to the concepts of mental health promotion, prevention and early intervention is demonstrated through rehabilitation strategies that target the need of the local catchment population, early identification and intervention, and with focus on vocational, educational, social and cognitive functioning of the individual consumer.
Information technology	Rehabilitation services are linked to existing mental health information initiatives, including MH-OAT and the Mental Health Information Development Project.
Continuity of care	Rehabilitation packages that are goal oriented and based on individual assessment are provided, with the primary goal of improving functional status and skills development.
Workforce development	Educational needs of the rehabilitation service and all multidisciplinary and affiliated staff, including NGOs, are met through relevant orientation, training and development programs. This includes the targeting of staff knowledge, skills and attitudes to ensure best practice, consistent with the <i>Framework for Rehabilitation for Mental Health</i> .
Partnerships	Specialist rehabilitation and long-term support services are delivered in partnerships between the local Area Health Service, non-government organisations, general practitioners, private psychiatrists and other government departments.
Monitoring and evaluation	Quality improvement activities are documented, enable continuous improvement, and incorporate the elements of input, process and outcomes measurement, consistent with policy initiatives for the use of mental health performance measurement tools.

NSW Implementation Strategy – Appendix D Rehabilitation for Mental Health

D Broad template for implementation plan – to be adapted to meet local Area needs and population health

Policy statement	Strategy	Outcome	Responsibility*	Time
<p>Organisational structures for governance and accountabilities</p> <p>Action 1</p>	<ul style="list-style-type: none"> Rehabilitation Development Groups will be established in each Mental Health Service, and include an identified chairperson Memberships will be multidisciplinary and include representation from consumers and carers, GPs and affiliated service providers, consistent with policy requirements (<i>Clinical rehabilitation on page 14</i>) A planned development and consultation process will be undertaken by the Rehabilitation Development Groups, to review local service components against template (Appendix D) and to ensure stakeholder input into planning processes 	<p>Rehabilitation Development Groups in each Mental Health Service, with Terms of Reference reflecting those of the framework</p>	<p>Area MH Director</p> <p>Area planning staff</p> <p>Consumer and carer groups</p>	<p>Dec 2002</p>
<p>Local service plans for clinical rehabilitation and disability support programs</p> <p>Action 2</p>	<ul style="list-style-type: none"> Mental health rehabilitation service planning and decision making is based on best available evidence and population health needs Service plans for rehabilitation and disability support programs, consistent with policy directions, will be developed 	<p>Rehabilitation Service Plans in each Mental Health Service, consistent with policy directions set out in the <i>Framework for Rehabilitation and Mental Health</i></p>	<p>Area MH Director</p> <p>Area planning staff</p> <p>Rehabilitation Development Groups</p> <p>Consumer and carer groups</p>	<p>June 2003</p>
<p>Linking existing information initiatives with local rehabilitation and disability support programs</p> <p>Action 3</p>	<ul style="list-style-type: none"> Mental health rehabilitation services will participate in information development and activity data collection, within existing and planned IT initiatives, such as the Mental Health Information Development Project and the Mental Health Outcomes and Assessment Training Project 	<p>Procedures for data collection, supported by networked computer technology</p>	<p>Area MH Director</p> <p>Rehabilitation Development Groups</p> <p>Consumer and carer groups</p> <p>Centre for Mental Health</p>	<p>June 2003</p>

* Suggested responsibility only – arrangements may vary according to organisational infrastructures and links to other service providers, including NGOs.

Policy statement	Strategy	Outcome	Responsibility*	Time
<p>'Rehabilitation Packages' and access best practice interventions</p> <p>Action 4</p>	<ul style="list-style-type: none"> Individually targeted 'rehabilitation packages' for a range of needs will be available in each Mental Health Service, and developed by the Centre for Mental Health in partnership with Area Health Services Access to clinical rehabilitation and disability support services at the local level will be actively promoted through partnerships with clinical services, including general practitioners, NGOs, and other government departments 	<p>A system of individually targeted, evidence-based and comprehensive care packages for a range of disorders with documented management plans and three-monthly reviews</p>	<p>Area MH Director</p> <p>Rehabilitation Development Groups</p> <p>Consumer and carer groups</p> <p>Centre for Mental Health</p>	<p>June 2003</p>
<p>Workforce development for multidisciplinary staff and affiliated service providers</p> <p>Action 5</p>	<ul style="list-style-type: none"> Learning and development programs will be developed for multidisciplinary workforce and Area personnel 	<p>Self-directed learning packages to support workforce development for staff in clinical rehabilitation and disability support services</p>	<p>Area MH Director</p> <p>Rehabilitation Development Groups</p> <p>Consumer and carer groups</p> <p>Centre for Mental Health</p>	<p>June 2003</p>
<p>Service evaluation for clinical rehabilitation and disability support programs</p> <p>Action 6</p>	<ul style="list-style-type: none"> Clinical rehabilitation and disability support services will participate in existing and planned quality and review activities, including mainstream health care review systems 	<p>A range of evaluation initiatives to monitor the quality of mental health rehabilitation and disability support services</p>	<p>Area MH Director</p> <p>Rehabilitation Development Groups</p> <p>Consumer and carer groups</p>	<p>Ongoing</p>

* Suggested responsibility only – arrangements may vary according to organisational infrastructures and links to other service providers, including NGOs.

Notes

