

NSW Older People's Mental Health Recovery-oriented Practice Improvement Project

STATEWIDE PROJECT
REPORT



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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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Foreword

Recovery is central to mental health policy in Australia, but there has been much less attention paid to what this means for older people than for people of other age groups. I encourage you to read this report which outlines the efforts of clinicians, managers, and the people they work with in New South Wales, to make recovery more than a word in a model of care.

The report provides detail about one approach to increasing the recovery orientation of services. If I wanted to be controversial I could suggest that the methodology chosen applied some of the principles of recovery-oriented practice to engaging staff in change. Rather than providing staff with a 'recovery model' to implement across the state, the project recognised that every service (and every clinician for that matter) is in a unique, individual, situation in terms of resources, context, roles and culture. In particular, staff were in very different stages of accepting the applicability of recovery concepts to older people.

Therefore the methodology used provided a simple goal (to increase recovery orientation) and empowered services and clinicians to choose whether to participate, and to choose their own actions, in an area seen as feasible and meaningful to those involved.

The results are mixed. Given a choice, over 70% of NSW Local Health Districts had teams who chose to commit to participation. Some services made major progress, others small steps. In some projects people with lived experience were central to developments, in others services didn't have the established relationships or ways of working to incorporate consumers. But all moved forward, and have contributed to services across the state committing to further change. All who participated, and supported those participating, need congratulations for challenging the mythology that 'recovery doesn't apply to older people' and being willing to put in time and commitment despite the risk of being perceived as different. In doing so, they have made steps towards 'different' being mainstream, with rewards for people with lived experience of mental illness and those who work with them.



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Acknowledgements

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Project team

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OPMH LHD recovery-oriented practice improvement champions and supporting managers

The project team would like to thank and acknowledge all of the consumers and local staff involved in each of the LHD projects. LHD project champions and supporting managers are listed below.

Central Coast LHD

OPMH recovery champions: Sharon Kakato, Grace Ongley

Supporting managers: Raichel Green, Dr John Dobrohotoff

Hunter New England LHD

OPMH recovery champion: Bryan McMinn

Supporting manager: Stephen Walker

Illawarra Shoalhaven LHD

OPMH recovery champions: Stephen Young, Eddie Zeballos

Supporting manager: Peter Pulcini

Murrumbidgee LHD

OPMH recovery champion: Joy Howell

Supporting manager: Pamela Brinsmead

Nepean Blue Mountains LHD

OPMH recovery champion: Brooke Ayton

Supporting manager: Julianne Radley

Northern Sydney LHD

OPMH recovery champions: Stephen Kay, Brooke Richards, Khima Neure

Supporting Managers: Julie Strukovski, Andrew Clement

South Eastern Sydney LHD

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Supporting managers: Dr Brian Draper, Liz Abbott

Sydney LHD

OPMH recovery champion: Ana Zotelo

Supporting manager: Jim Pulious

St Vincent's Health Network

OPMH recovery champion: Jennifer Kelly

Supporting Manager: Dr David Burke

South Western Sydney LHD

OPMH recovery champions: Regina McDonald, Cheryl Mitchell

Supporting manager: Ruth Ferrington

Western NSW LHD

OPMH recovery champions: Kristen Szulik, Zita Spicer

Supporting manager: Ian Rawson

Western Sydney LHD

OPMH recovery champions: Dayle Tierney, Suellen Haskins

Supporting managers: Dr Suman Tyagi, Skirma Cervin

Glossary of acronyms

CALD – Culturally and linguistically diverse

LHD – Local health district

MHB – Mental Health Branch

NHS – National Health Service (UK)

OPMH – Older people's mental health

OPMHPU – Older People's Mental Health Policy Unit

SMHSOP – Specialist mental health services for older people

HETI – Health and Education Training Institute

CNC – Clinical Nurse Consultant

Executive summary

The Older People's Mental Health (OPMH) Recovery-oriented Practice Improvement Project aimed to promote recovery-oriented practice in NSW OPMH community and inpatient teams across NSW. It did this through a number of strategies:

- developing and promoting recovery-oriented practice resources such as a OPMH Recovery Toolkit resource and facilitating recovery training workshops
- promoting and supporting recovery-oriented practice improvement projects in Local Health Districts (LHDs) led by identified 'recovery champions' through a 'start where you can' project approach that used existing resources, and
- evaluating and disseminating project outcomes, including promoting projects through statewide benchmarking forums and via a specific OPMH recovery-oriented practice forum.

The project was coordinated and led by the MHB OPMH Policy Unit and informed by advice from the OPMH Recovery Project Steering Group, who identified the key messages for the statewide project and provided ongoing overarching guidance and support. The role of the steering group was expanded during the project at the request of LHD champions who wanted ongoing feedback and advice on their individual LHD projects. Clinical practice improvement was approached using the methodology of the NSW Clinical Excellence Commission's clinical practice improvement framework.ⁱ As part of the statewide project, LHDs successfully recruited local 'recovery champions' in 12 LHDs who initiated 16 projects across NSW.ⁱ Thirteen of the LHD projects across 11 LHDs progressed to final completion for inclusion in this statewide report.

There was a variety of projects undertaken as part of the statewide project. The key elements of recovery-oriented practice identified in the National Recovery Framework and the accompanying practitioner guide were used to guide the statewide and LHD projects.ⁱⁱ Therefore, LHD projects are grouped below by the key elements of recovery-oriented practice identified in the Framework.

Uniqueness of the individual: *Lost in translation: a longitudinal study of culturally-sensitive recovery-oriented practice among CALD consumers (Syd LHD); Increasing the effective use of wellness plans with consumers of OPMH services (SWS LHD), and Managing our Care (WNSW LHD).*

Real choices: *Re-orienting staff to recovery-oriented practice through education and introducing collaborative care planning practices (IS LHD), and Involving consumers and carers in developing wellness plans and recovery goals in care plans (Murr LHD).*

Attitudes and rights: *Measuring the recovery attitudes of NSLHD OPMH clinical staff (NS LHD).*

Dignity and respect: *OPMH peer workforce (CC LHD), and Club HARP (SVHN).*

Partnership and communication: *Road of Recovery (CC LHD), and Blacktown OPMH: Early Wellness Planning (WS LHD).*

Evaluating recovery: *The evaluation of the eastern suburbs mental health service's older person's recovery suite (SES LHD); Recovery-oriented linguistic analysis of Collaborative Care Management Plans (HNE LHD), and Merrylands OPMH: Mental Illness self-management through Wellness and Care Plans (WS LHD).*

A literature scan was conducted to inform project planning and implementation. It identified several challenges such as the lack of a broadly agreed definition of recovery-oriented practice and a lack of measures specifically designed to measure recovery outcomes among older mental health consumers. It also confirmed the project premise that there is lack of research around recovery in an older people's mental health context. The literature scan guided the development of a OPMH recovery-oriented practice improvement toolkit for the identified LHD OPMH recovery champions to support the development and implementation of their LHD recovery-oriented practice improvement projects. Building on the toolkit, education workshops were held for the LHD champions to help guide and support the development of LHD projects that were later showcased at a state-level OPMH recovery practice-improvement forum.

The project adopted a ‘start where you can’ approach, ensuring that those LHDs that had fewer resources to support a project were able to start their recovery journey with smaller, more achievable projects and as their project developed, they were able to continue that journey in other ways. This approach also allowed for some LHDs to pursue more ambitious projects where they had existing staffing resources and/or structures in place, or were able to secure project funding.

The project has been very successful in starting a conversation about recovery and recovery-oriented practice in older people’s mental health OPMH services. The LHD projects have promoted understanding, discussion, support, reflection and positive experiences around recovery-oriented practice in OPMH services. Despite some common challenges, the statewide project has successfully delivered positive changes in practice and culture in OPMH services across most of NSW. The project found that for OPMH services and consumers, recovery-oriented practice is achievable, and has some specific characteristics. For older people with mental illness, recovery can be seen as *continuing to be me*, or continuing/regaining an enduring sense of identity, drawing on a lifetime’s experience, coping strategies and resilience. This contrasts with younger people, who are often still establishing their identity, coping strategies and resilience as part of their recovery journey. This means a slight rethink about how we approach recovery for older consumers of mental health services, even if some of the fundamental ideas are very similar.

The involvement of a consumer consultant on the state-level project steering group was invaluable for the state-level project team and steering group, as well as the LHD project champions. Consumers were involved at various levels in some LHD projects. LHDs that engaged consumers as collaborators in their projects reported that their involvement was transformative both in the approach taken and in staff and stakeholder perceptions of the project. The project findings strongly support consumer and carer involvement in project design and planning, delivery and evaluation in implementing recovery-oriented practice and fostering a shift in service approach and culture.

The project found that group recovery/wellness programs are highly valued by older consumers and can promote peer support and social connectedness. Wellness planning was found to be useful as a recovery and self-management tool for consumers, particularly following discharge.

A focus on collaborative care planning and identifying consumer recovery goals in a collaborative care planning process with consumers of OPMH services can be successful, particularly when supported by engaging, targeted training strategies.

At a statewide level, recovery-oriented practice within OPMH services needs to remain a focus within clinical benchmarking as well as being promoted in models of care and policy documents. Recovery-oriented practice also needs to be a focus within ongoing workforce development strategies. Recovery for older people with mental illness and recovery-oriented practice with these consumers should be a focus area for future research as this is still a relative gap in the published literature. To support sustainable change, the OPMH Policy Unit and LHD OPMH services will seek to continue the conversation and momentum around recovery-oriented practice through this report and other presentations, publications and strategies.

The OPMH Recovery-oriented Practice Improvement Project

The OPMH Recovery-oriented Practice Improvement Project aimed to promote recovery-oriented practice in NSW OPMH community and inpatient teams across NSW. It did this through the development and promotion of effective recovery-oriented resources such as a OPMH Recovery Toolkit, by promoting and supporting effective recovery-oriented practice improvement projects in Local Health Districts (LHDs) led by identified 'recovery champions', and by the evaluation and dissemination of project outcomes.

Background

Over the last decade, the recovery movement has strongly influenced mental health policy and service delivery. There is currently a strong service user and government policy agenda to promote practice in mental health services that actively supports the recovery of service users. Recovery-oriented practice refers to the application of sets of capabilities that support people to undertake the journey of individual recovery. There has been limited work done in Australia (or overseas) focusing on understanding and promoting recovery-oriented practice specifically within an older people's mental health context. Relevant research and practice development work has been undertaken in the UK by Daley et al and this project built on that body of work. The project was fortunate to have Dr Stephanie Daley available to provide insights into the key successes and challenges found in implementing a similar older people's mental health recovery practice improvement project with the South London and Maudsley NHS Foundation Trust in the United Kingdom.

The *National Framework for Recovery-Oriented Mental Health Services* was released in 2013 and provides a focus and conceptual framework for promoting recovery-oriented mental health services, summarising Australian context and definitions of the concepts of recovery and lived experience. It outlines the policy context for a move to recovery-oriented approaches and cites relevant research. The National Recovery Framework summarises the key elements of recovery as the

uniqueness of the individual, real choices, attitudes and rights, dignity and respect, partnership and communication, and evaluating recovery. This project report is structured and framed according to these key elements of recovery.

Research by Daley et alⁱⁱⁱ suggests that there are several key differences in how the principles of recovery apply to older people as distinct from the general adult population experiencing mental illness. Three components of recovery appear to be distinct to older people: the significance of an established and enduring sense of identity; coping strategies which provide continuity and compensation and therefore reinforce identity, and the impact of coexisting physical illness.ⁱⁱⁱ Individual recovery at any age is a unique and personal journey to live a meaningful and contributing life in a community of choice, with or without the presence of mental health issues. Older consumers have described this as 'continuing to be me'.

Individual or personal recovery has a complex relationship with clinical recovery focused on reducing or eliminating symptoms and restoring social functioning. Older people tend to have a clear sense of identity (who they are) and how they define themselves, which appears to buffer the impact of the illness. Younger consumers may still be developing their sense of identity whereas older consumers tend to know who they are, built on a lifetime's experience.ⁱⁱⁱ The importance of an established and enduring sense of identity is central to the recovery journey of older consumers. Daley et alⁱⁱⁱ found that the practical implications related to adopting a recovery-oriented practice model in older people's mental health services include the need to focus on the maintenance of identities such as continuing long-term friendships, social networks, and established roles. For people with dementia, key factors that further influence experiences of recovery appear to be the changing balance over time from personally initiated strategies, which provide compensation and enable continuity, and to support from others.ⁱⁱⁱ

Embedding values of empowerment, agency, and self-management within service delivery are key practice implications that need to be considered.

This project aimed to promote recovery-oriented practice in an older people’s mental health context in collaboration with staff and consumers, supported by the relevant literature, training, and evidence-based resources. The project did this by identifying and supporting recovery-oriented practice improvement in a self-selected set of LHD OPMH community and inpatient services across NSW, with projects developed and led by local ‘recovery champions’ and supporting managers. The project also aimed to contribute to the evidence base (published and unpublished) about recovery and recovery-oriented practice with older people with mental illness.

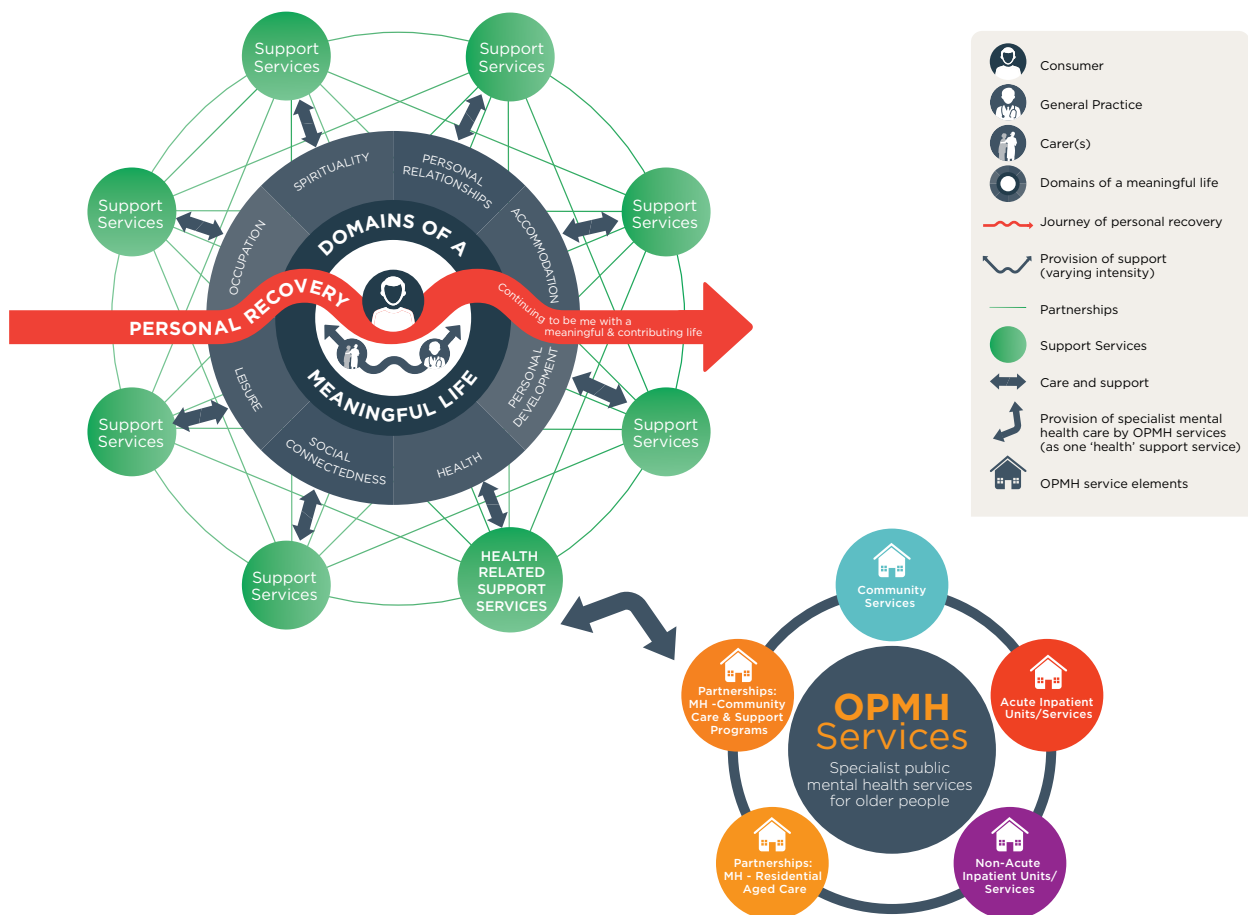
NSW context

The Mental Health Branch (MHB) Older People’s Mental Health (OPMH) Program is a key program within the NSW Mental Health Program. It covers Older People’s Mental Health(OPMH) community, non-acute and acute inpatient services and community residential services for older people with mental illness, as well as broader strategies, partnerships and State-Commonwealth inter-

jurisdictional arrangements to address the mental health needs of older people. In 2017, NSW Health released a statewide plan – the *NSW Service Plan for Older People’s Mental Health Services 2017-2027* – building on a previous 10-year plan. The new plan and other key bodies of work within the OPMH Program have been informed by this statewide project, promoting recovery-oriented practice as a key principle and priority in OPMH services across NSW.

Project objectives and approach

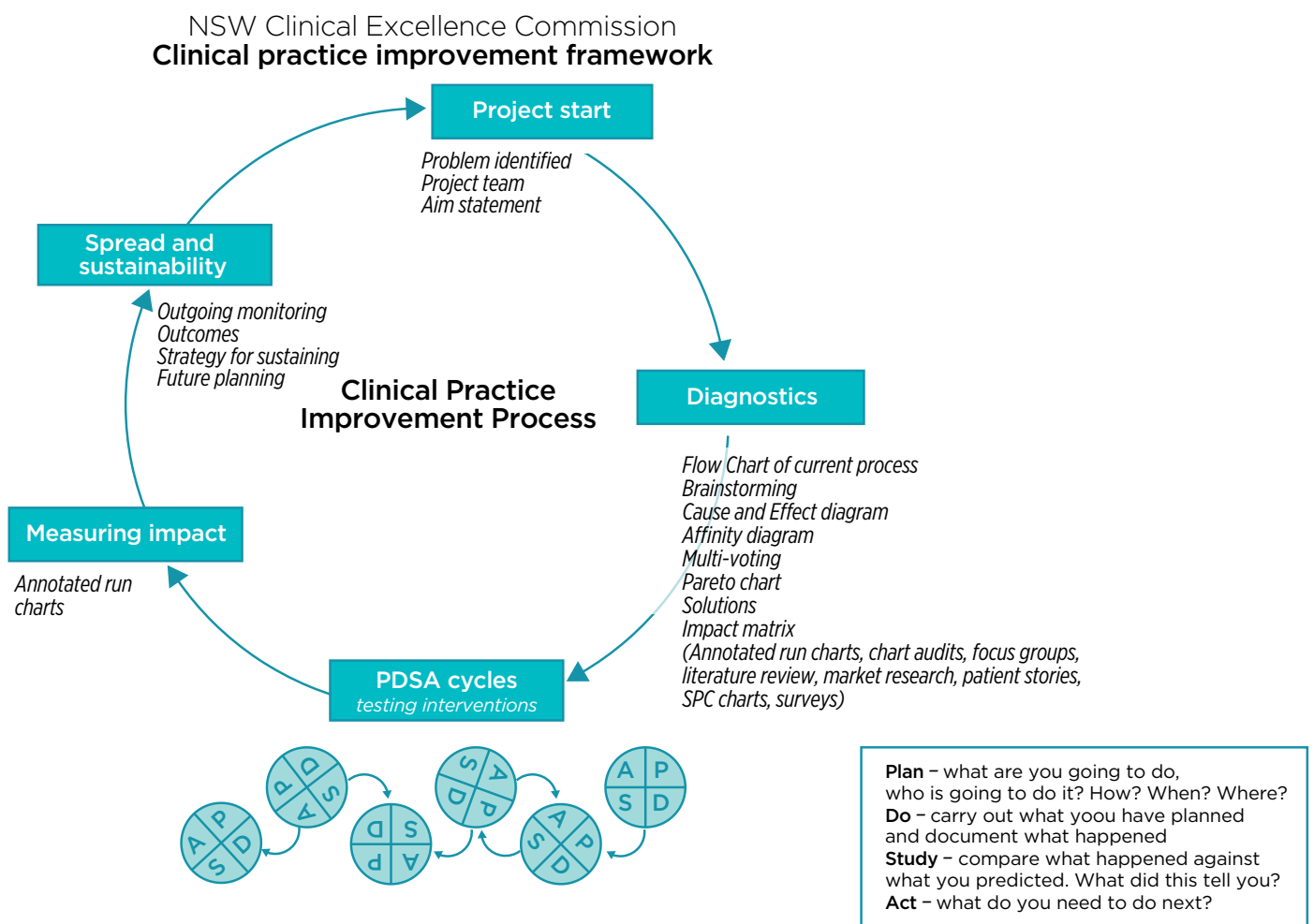
The project was coordinated and led by the MHB OPMH Policy Unit and informed by advice from the OPMH Recovery Project Steering Group, formed to provide guidance on the project. The Steering Group was comprised of key representatives from the NSW Ministry of Health MHB and Local Health District mental health services, discipline-specific members (allied health, nursing and medical), a consumer consultant and peak carer and provider organisation representatives (Transcultural Mental Health Centre, Mental Health Coordinating Council and Mental Health Carers NSW). The project steering group also included Dr Daley, who provided expert advice based on the experience of implementing recovery-oriented practice improvement initiatives in the UK.



Clinical practice improvement was approached using the methodology of the NSW Clinical Excellence Commission's clinical practice improvement framework, as shown in the following figure.^{iv}

In consultation with the project steering group, the project team identified the following key project objectives and strategies:

- To promote recovery-oriented practice in NSW OPMH community and inpatient teams across NSW through the development and promotion of effective recovery-oriented resources, and by developing and promoting effective recovery-oriented practice improvement projects in LHDs, led by identified 'recovery champions'.
- To develop a useful OPMH recovery-oriented practice improvement toolkit for NSW OPMH services, to support and complement a UK online recovery training module.
- To develop an online presentation that puts the subject material, including the above mentioned UK online training, into an Australian context for LHD recovery champions, to be hosted centrally online with other project materials.
- To resource and support key LHD OPMH clinicians as 'recovery champions' to reflect on recovery and recovery-oriented practice in the OPMH context, and identify local recovery practice improvement projects, including through a face to face workshop for LHD recovery champions and their managers.
- To support the implementation of LHD recovery practice improvement projects through an online portal and via the project steering group meetings.
- To evaluate, disseminate and promote practice improvement strategies, resources, and a OPMH recovery-orientated practice improvement toolkit to foster an ongoing focus on recovery-oriented practice improvement in older people's mental health.
- To add to the current literature around recovery-oriented practice with older mental health consumers and to encourage and support LHD champions to publish the findings of their projects into the current peer review literature.
- To implement the project using existing NSW Health and Local Health District resources.



The project adopted a collaborative approach to the development of a OPMH recovery-oriented practice improvement toolkit, driven by the needs of consumers, carers, and clinicians. It was intended that the toolkit would complement existing online training developed by the South London and Maudsley NHS Foundation Trust.

The key phases in the project methodology are outlined below.

1. Project planning and initiation, confirming project goals and deliverables
2. Establish OPMH Recovery Project Steering Group
3. Literature and policy scan
4. Develop OPMH recovery toolkit document to compliment NHS online training
5. Recruit LHD 'recovery champions' and workshop toolkit package
6. Support champions in establishing local recovery practice improvement projects
7. Evaluation and showcasing of LHD projects
8. Sustaining improvement and focus

The project promoted an inclusive and collaborative approach between the project steering group, LHD OPMH recovery champions, and LHD OPMH supporting managers. This was to address a number of challenges regarding clinician engagement and project leadership identified in a related project conducted in the UK by Daley et al.ⁱⁱⁱ

The scope of the project was focused on OPMH inpatient and community services across NSW who participated on a voluntary basis. Participating services and projects were nominated by their LHDs. In terms of scope, the project covered a range of recovery-oriented practice improvement priorities identified by LHD recovery champions at the local level.

Key Messages

The project steering group identified the following key messages specific to recovery in older people's mental health to promote throughout the project.

1. Individual personal recovery at any age is a unique and personal journey to create and live a meaningful and contributing life in a community of choice, with or without the presence of mental health issues. Older consumers have described this as 'continuing to be me'.
2. Individual personal recovery has a complex relationship with clinical recovery which is focused on reducing or eliminating symptoms and restoring social functioning.
3. Recovery-oriented practice refers to the application of sets of capabilities that support people to undertake the journey of individual recovery.

Implementation

The project successfully recruited LHD OPMH recovery champions and supporting managers from 12 LHDs. This accounts for a significant proportion of the 17 Local Health Districts and speciality networks in NSW. Recruitment of these champions was conducted via the statewide OPMH Advisory Group and the project steering group. Learning from the UK experience, the project asked for LHDs to appoint a mixture of nursing, allied health and medical staff to their projects as champions and supporting managers. Training materials and an OPMH recovery-oriented practice improvement workshop were developed for the champions and supporting managers with a pre-workshop webinar to orientate them to the concepts of recovery in an Australian OPMH context. Both the online pre-workshop webinar and the face-to-face workshops were delivered in collaboration with the NSW Institute of Psychiatry (now part of HETI – Mental Health). These sessions were also recorded and kept as additional resources for the projects toolkit resource.

Following the workshops the project team supported the LHD OPMH recovery champions in identifying 16 recovery-oriented practice improvement projects from across 12 Local Health Districts. LHD champions were encouraged to involve consumers in the planning and development of their projects where possible. The projects ranged in size and scope from recruiting and implementing an older person's peer workforce to smaller workforce training and development projects.

Of the 16 identified projects across the 12 Local Health Districts, 13 projects from 11 Local Health Districts progressed to implementation and have been outlined in this report.

Resources that were developed and utilised as part of the project

Project literature scan

A literature scan was conducted to inform project planning and implementation. This was conducted in consultation with the project steering group and was used to guide the development of the toolkit resource and training workshops.

The literature scan confirmed several challenges that were anticipated by the project team. Key among these was the lack of a broadly agreed definition of recovery-oriented practice. The project team elected to use the definition of personal recovery cited in the Australian national mental health recovery framework guide for practitioners and providers.ⁱⁱ

Personal recovery is defined within this framework as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.

A national framework for recovery-oriented mental health services: guide for practitioners and provider, p.11

Consistent with the lack of research around recovery in an older people's mental health context, it was also found that there is a lack of measures specifically designed to measure recovery outcomes within the older cohort of mental health consumers. The literature scan highlighted a need to adapt existing concepts and definitions to align with the specific needs of older mental health consumers. The literature scan also identified a need to clearly differentiate personal recovery from clinical recovery as the two philosophies were not always clearly defined and differentiated in the literature. The project aimed to promote a focus on personal recovery alongside the more familiar focus of services on clinical recovery.

The literature scan process informed a review of 49 candidate recovery-oriented practice evaluation tools. On further review the project steering group distilled this to five recommended measures; four instruments designed to measure individual recovery and one instrument (STARS) designed to measure the recovery orientation of staff. Based on expert advice and the findings within the literature scan, preference was given to measures containing

30 items or less. It was felt that 30 items was a realistic limit for clinical staff and consumers to complete in a clinical setting. Unfortunately all of the recommended measures were a 'close enough fit' for the target group of older consumers of mental health services but none could be considered 'ideal' for the purposes of the project given the lack of research around recovery-oriented practice with this group.

Recommended evaluation tools

Consumer measures

- Goal Attainment Scale (Modified)
- Stages of Recovery Instrument 30 (STORI-30)
- Self-Identified Stage of Recovery (SISR)
- Short Interview to Assess Stages of Recovery (SIST-R)

Service level measures

- Staff Attitudes to Recovery Scale (STARS)

The literature scan highlighted the research by Daley et al,ⁱⁱⁱ who are among the few researchers to publish a recovery-oriented paper that specifically discusses the needs of older consumers of mental health services. Their research findings are summarised earlier in this report. It helped shape discussions with LHD OPMH recovery champions in developing their projects and was essential to discussions around consumer and carer involvement in care planning and discussing the role of peer workers in proposed projects.

A 'start where you can' philosophy for LHD projects

In discussing the project with LHD stakeholders it was evident that the participating Local Health Districts were at different stages in their own journey around exploring recovery-oriented practice within the context of their local mental health services. Some had looked at recovery-oriented practice in their inpatient or community teams; some had already established programs; others were yet to consider the implications of recovery-oriented practice and this project was an impetus for local services to start their journey. Because of this, a 'start where you can' philosophy was undertaken with the LHD champions when discussing what kinds of projects they might consider establishing as part of the statewide project. For some champions, reviewing existing programs, adapting programs for older consumers or establishing entirely new programs in their local services was seen as a good place to start, whereas for other champions their

projects were more about starting a conversation at the local level through staff training and development. A 'start where you can' approach also allowed champions to consider their local projects within the confines of what local resources they had to support them.

Recovery-oriented practice improvement toolkit

The OPMH recovery-oriented practice improvement toolkit was developed for the identified LHD OPMH recovery champions to support the development and implementation of their LHD recovery-oriented practice improvement projects. It sought to bring all of the currently available resources together. The resources listed in the toolkit needed to be cost neutral as the LHD projects were to be implemented using existing resources. In reviewing the potential resources for inclusion, it quickly became evident that the size of the toolkit had to be managed. To make it user-friendly, it was divided into several tabbed sub-sections.

Section 1 outlined the context for this project by taking the contemporary material regarding recovery and putting it into an Australian older people's mental health (OPMH) context. It aimed to provide local OPMH recovery champions and OPMH staff with a sound foundational knowledge of recovery in OPMH from which to develop local recovery practice improvement projects. This section also included links to the UK online training. Feedback indicates that this section was also used by LHD champions in other ways such as the development of local training resources and ethics applications.

Sections 2 to 4 of the resource outlined a number of resources that OPMH teams might consider in developing their own practice improvement projects. These were divided into a section that focused on national recovery framework resources, a section on service planning resources and a section outlining a number of other information and resources that might be useful for specific population groups. A fifth section outlined the five recommended evaluation tools with links to enable access. Interestingly, the evaluation tools were not as widely used as anticipated with many projects opting to measure outcomes via internal audit processes.

The UK online training

The project toolkit resource linked recovery champions and their managers to a free e-learning course developed by the UK NHS for health professionals and care support staff. The online training seeks to increase the user's awareness of recovery-focused practice and the application of its principles to the care of older people living with dementia and other mental health problems. The training does this by using real-life case studies and video interviews with service users, carers, and staff. The online training package covers 5 modules that can be completed separately, and should take up to 4 hours in total to complete.

The five modules in the UK online training

Module 1: Introduction to Recovery Practice

Module 2: Recovery and Older People

Module 3: Maintaining Identity

Module 4: Enhancing Resilience

Module 5: Meaningful Service User and Carer Involvement

LHD champions and managers provided positive feedback about the flexibility of completing this training one module at a time around clinical demands. Many LHDs used the training as a key element of their projects, either as an initial strategy to support staff engagement in their chosen project, or as a specific training project to help re-orient their service towards recovery.

Recovery-oriented practice improvement workshops

The project team organised two workshops for the LHD recovery champions and their supporting managers. The first workshop was an online webinar that sought to place recovery-oriented practice into an Australian context, as much of the literature on recovery-oriented practice and the few papers on how it relates to older consumers of mental health services were published by overseas experts. The webinar also helped contextualise the UK online training. To this end LHD champions were asked to complete the UK online training prior to the webinar. The presentation slides used for the webinar and a recording of it were made available and added to the project toolkit resource.

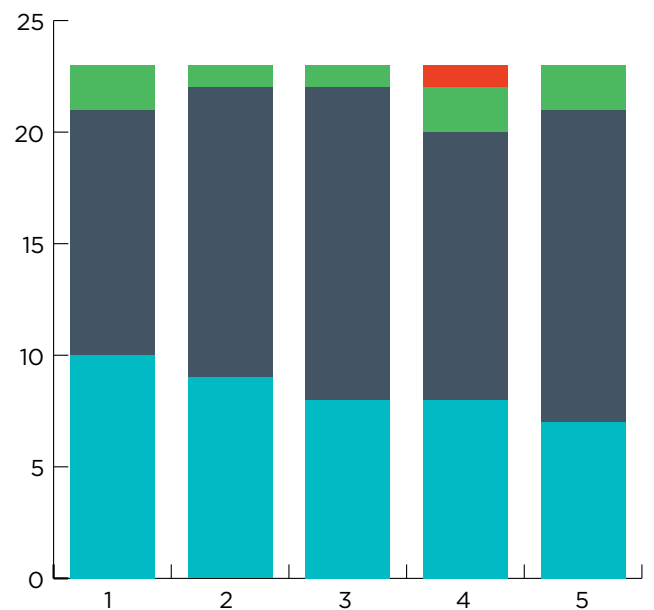
A full day face to face recovery-oriented practice improvement workshop was delivered following the webinar in partnership with the NSW Institute of Psychiatry (now HETI – Mental Health). Due to high demand, this workshop was run twice with two cohorts of LHD champions and their managers. In total, 36 LHD recovery champions and supporting managers attended one of the workshops. These workshops covered the key elements of the project toolkit resource and its use, in addition to a pre-recorded address by Dr Stephanie Daley that covered the UK experience and the challenges and successes of their project. The workshops also focused on group ‘brainstorming’ sessions where potential LHD projects could be discussed within the context of the statewide project. Ideas for LHD projects were discussed in a group with a focus on basic project design, implementation challenges and evaluation. The project’s consumer consultant participated throughout all of the workshops, giving a presentation on her experience, and was involved in the discussion throughout both workshops, providing her insights and feedback on LHD project ideas.

By request of the workshop participants, the presentation slides and templates created for the workshops were added to the toolkit as further training resources. The policy context, consumer’s perspective, and introducing the toolkit sessions were also recorded and uploaded to an online hub for LHD champions to access and use as part of their projects.

A feedback survey was conducted following each workshop session. Participants were asked to answer a 10 question feedback survey comprising of five Likert scale questions relating to participant expectations and how useful the material would be for improving local practice. The other five questions were long answer questions asking participants to note the most beneficial areas of the workshop and provide specific feedback on the toolkit and areas for improvement with the workshop. The feedback survey had a response rate of 64% across the two workshops.

Overall, the feedback was very positive (see following figure). Over 90% of all respondents indicated that the workshops met their expectations and that the information was appropriate for their requirements. Over 80% of respondents indicated that the workshop information was useful, would assist in engaging staff to review clinical practices and would leave to improvements in their service.

Based on long answer feedback, the agenda for the 2nd workshop was adjusted to allow more time for the project’s consumer consultant to talk about recovery from the consumer’s perspective and to briefly co-present on consumer engagement and consultation. The co-presentation around consumer engagement incorporated the lessons learn from a consumer-driven project that had already been undertaken in Western Sydney LHD.



1. My expectations of today's forum were met
2. The level of information presented was appropriate and met
3. The information provided was constructive and useful
4. Information from the forum will assist engaging local staff in reviewing clinical review practice
5. I am confident that the planned direction of the forums will lead to improvements in my service



OPMH recovery forum

A recovery forum was hosted in May 2017 to showcase a number of the LHD projects and to bring the statewide project together. The forum was attended by 47 stakeholders from across NSW, and there was strong LHD representation from most LHDs as well as representation from external stakeholders including the NSW Mental Health Commission, Transcultural Mental Health Centre, BEING, and NSW Mental Carers. Hosted by the NSW Institute of Psychiatry (now HETI – Mental Health), the forum featured addresses by NSW Mental Health Commissioner John Fenely,

Project Clinical Lead Dr Rod McKay, Project Policy Lead Dr Kate Jackson and Project Consumer Consultant Ms Sharyn McGee. Eight of the LHD projects were presented followed by a reflective panel discussion with the forum attendees about the project journey and future directions for recovery-oriented practice within NSW older people's mental health services. The session was also recorded, with the video content of the forum and has been made available as a resource for future recovery projects. The forum was very successful in providing LHD champions with a platform to discuss their projects with their peers, and several LHDs managers expressed interest in establishing several similar projects to the ones presented as a way of further progressing the recovery orientation of their services.

Project communiqués

Regular project communiqués were key to the project's communication strategy, distributed throughout the project to highlight key project progress and directions, and keep project participants and service managers engaged. Each communiqué was limited to 1-2 pages and sent to LHD OPMH staff via their LHD Director of Mental Health. The first communiqué was distributed in June 2015 to promote awareness of the project and help recruit LHD recovery champions. Subsequent communiqués focused on project achievements and directions. The project communiqués and a communiqué template were also archived on the project's online hub (Moodle) for use by LHD champions in promoting their local projects.

Online resource hub (Moodle) and discussion forum for LHD champions

Following the face to face recovery workshops, there were a number of requests for direct access to the content listed in the toolkit as LHD champions preferred to review each of the resources in one place rather than accessing the resources via hyperlinks in the project's toolkit document. The project team also needed to find a way of hosting the video recordings of the workshop sessions. With the support of the NSW Institute of Psychiatry (now HETI - Mental Health), an online Moodle site was developed for the LHD champions to access all of the resources in one place. The project team first attempted hosting the files on a cloud (Dropbox) but found that some staff in some LHDs were unable to access the content this way. As a solution it was agreed that an online Moodle would be established, with the Health Education and Training Institute (HETI) offering to host the Moodle on their already established e-learning platform. The Moodle would also host a discussion forum where LHD champions could ask questions and seek advice out-of-session.

The main benefit of hosting the online Moodle was that it allowed the LHD champions to access and view resources online in the Moodle itself, and as HETI's site should have been on all LHD's 'safe list' for internet access, there were no reported issues in downloading files, noting that this was not the case for the life of the project. Following the launch of the Moodle the only requests received were for user access/password resets. The adoption of a Moodle resolved most of the previous IT/project material access issues and was regularly accessed by a number of the participating LHD champions.

| NSW Older People's Mental Health Services Recovery-Oriented Practice Forum | | |
|--|--|--|
| Friday 19 May 2017 Lecture Room 1 HETI Mental Health, Parramatta Campus 5 Fleet St, North Parramatta For bookings contact John.Stevens@health.nsw.gov.au | | |
| 09:30 | Welcome | Dr Rod McKay |
| 09:45 | Opening address | |
| | Launch of the Community older people's mental health services: A guide for older people with mental health problems, and their families | NSW Mental Health Commissioner John Fenely |
| 10:00 | Older people's mental health recovery and recovery-oriented practice | Dr Kate Jackson Dr Rod McKay Sharyn McGee |
| Morning tea and coffee (10:45-11:00) | | |
| 11:00-11:30 | Developing an older people's mental health peer workforce and Roads to Recovery program | Raichel Green Central Coast LHD |
| 11:30-11:50 | Managing our care: community-based support for the consumer's recovery journey through education, resources and opportunities for social connectedness | Kristen Szulik and Zita Spicer Western NSW LHD |
| 11:50-12:10 | Using wellness planning to inform consumer care plans | Joy Howell Murrumbidgee LHD |
| 12:10-12:30 | Club Harp: a consumer-driven recovery-focused group providing health promotion, psychoeducation and peer support in an outpatient setting | Catherine Friel Kate Green St Vincent's Health Network |
| 12:30-12:50 | Evaluation of the Eastern Suburbs older people's mental health service recovery suite | Daniella Kanareck & Natalie Narunsky South Eastern Sydney LHD |
| Lunch (12:50-13:30) | | |
| 13:30-13:50 | Collaborative care planning in older people's mental health | Eddie Zeballos & Stephen Young, Illawarra Shoalhaven LHD |
| 13:50-14:10 | Measuring the recovery attitudes of older people's mental health service staff | Andrew Clement Northern Sydney LHD |
| 14:10-14:30 | Collaborative wellness and care planning with CALD communities | Ana Zotelo Tanika Mychael |
| 14:30-15:20 | Reflecting on recovery - interactive panel discussion | Sharyn McGee Assoc. Professor Peter McGeorge Jonathan Harms Dr John Dobrohotoff |
| 15:20 | Summation and future directions | Dr Rod McKay |

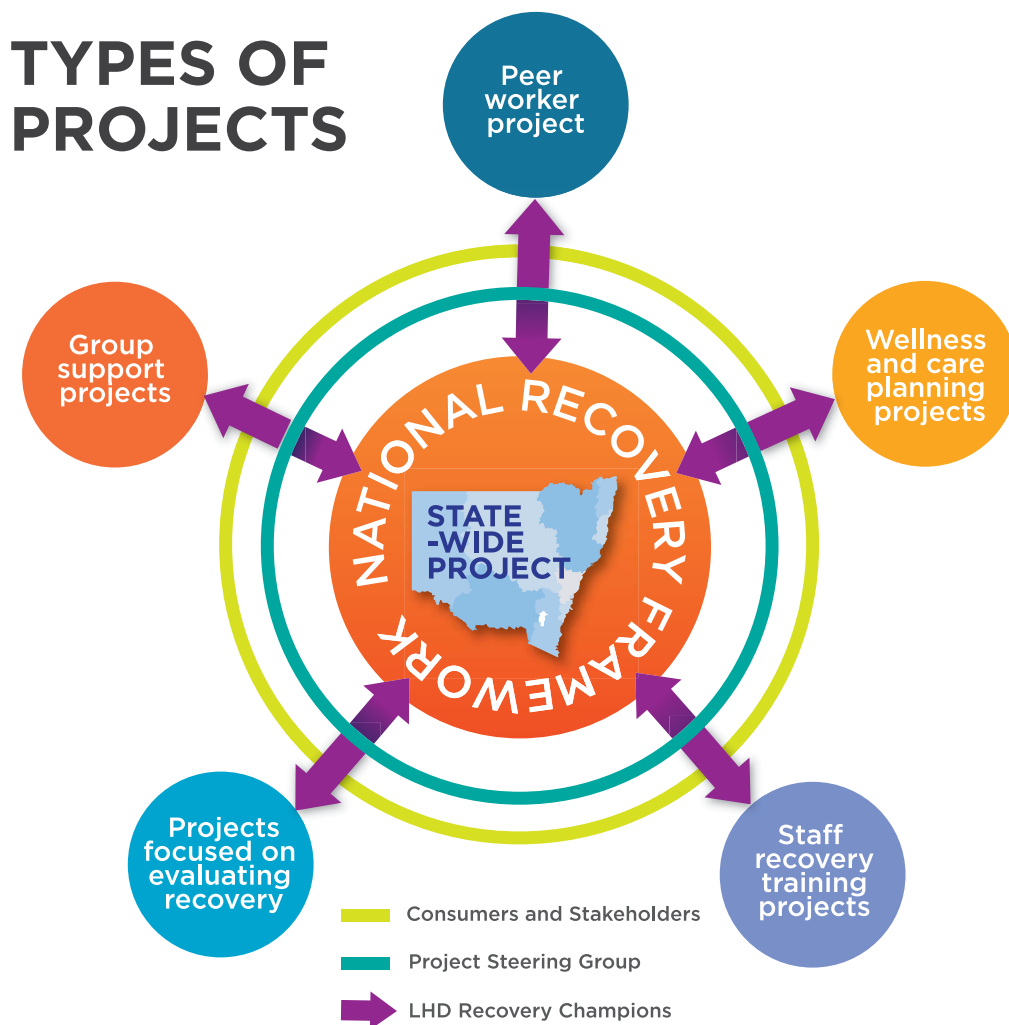
The discussion forum was underutilised, but this may have been due to its late introduction to the project. The Recovery Toolkit is now available to NSW Mental Health staff via the NSW Mental Health Workforce Portal, hosted by HETI.

Project steering group

The role of the project steering group was expanded during the project at the request of LHD champions who wanted ongoing feedback and advice on their individual LHD projects. To accommodate this request, roughly one-half of the regular steering group meetings were allocated to allowing the LHD champions to telephone into the meeting to gain feedback and advice. Prior to the meetings the LHD champions would provide a brief written update that they could expand on and discuss at each meeting. Most LHD project champions felt that having access to expert advice and feedback through the establishment and evolution of their projects helped them significantly. This process also allowed other champions to tune into the challenges and questions other champions were having, establishing an effective feedback network for all of the projects.



Project outcomes: LHD recovery-oriented practice improvement projects

There was a variety of projects undertaken as part of the statewide project. The graphic below illustrates the types of projects that were undertaken and the structure that supported their design and implementation.



An overview of each LHD project is provided in the following pages. The projects have been grouped by the key elements of recovery-oriented practice identified in the national recovery framework and the accompanying practitioner guide, as outlined below.^v

Practitioner guide to recovery principles that support recovery-oriented mental health practice

 These 'reflective questions' emphasise the fundamental importance of a recovery focus for clinicians and mental health service providers in the delivery of quality care. 

1. Uniqueness of the individual

Do I support the consumer and carer to build on their unique strengths and encourage them to take responsibility as they are able?

Do I routinely assess and discuss with the consumer and carer the importance of physical health and overall wellbeing?

Do I consider the possible effects of trauma in the lived experience of the consumer and carer?

2. Real choices

Do I provide sufficient information to support the consumer and carer to make informed choices?

Do I, as much as possible, facilitate the consumer being able to discuss very difficult choices?

Do I try to understand these difficult choices from the consumer and carer's perspective?

Do I welcome the carers and family members and provide as much information and support as possible to make them feel included and assist them to make informed choices?

3. Attitudes and rights

Do I respect and promote the consumer's legal and human rights?

Do I, at all times, behave so as to convey an attitude of respect for the person and a desire for an equal partnership?

Do I encourage the consumer to maintain social, family and friend connections?

4. Dignity and respect

Do I welcome the consumer and carer/support person to the service, and continue to do so?

Do I make the environment physically and emotionally safe for the consumer and carer/support person?

Do I listen to, and support, the consumer and carer/support person to define their recovery goals?

5. Partnership and communication

Do I proactively involve the consumer, carer/support person in their individual care planning, treatment or reviews?

Do I proactively link other services and supports to facilitate the consumer's recovery goals?

Do I proactively link other services and supports for carers and family members to assist them in their caring role?

6. Evaluating recovery

Do we, as individuals and as a team, utilise consumer and carer/support person feedback fully to improve service delivery?

Do we, as a team, assess and evaluate recovery outcomes within our work?

Do we regularly assess, with the consumer and carer, recovery outcomes and use these measures to improve treatment, care and support goals?

Do we include carers and family members in regular assessments and measures on recovery outcomes for the consumer?

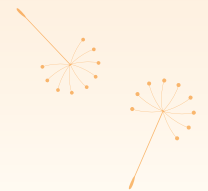
Do we provide training in recovery-oriented practice to clinical practice professionals?

Does the service act to implement recovery across multiple levels of service delivery?

Do we, as a service, support adequate tools, resources and training to embed recovery-oriented practice across the whole service system?

Do our day to day monitoring and evaluation systems reflect recovery capabilities?

Do we, as a service, evaluate recovery outcomes to drive quality improvement?



Uniqueness of the individual

The following LHD projects aimed to recognise and work with the unique strengths of people who seek support from NSW older people's mental health services. A person's experience of recovery is as unique as their experience with mental health issues. These projects focus particularly on acknowledging and responding to the diversity of people's values and experiences, linking with each individual's unique strengths, circumstances, needs, preferences and beliefs, and encouraging people to take responsibility as they are able.

[Recovery is] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Anthony, W 1993 'Recovery from mental illness: the guiding vision of the mental health service system in the 1990s', *Psychosocial Rehabilitation Journal*, vol. 16, pp. 11-23.^{vi}

SYDNEY LHD

Lost in translation: a longitudinal study of culturally-sensitive recovery-oriented practice among culturally and Linguistically Diverse (CALD) consumers

Context and project design

The project sought to address the question of whether a culturally-sensitive approach to the completion of the consumer wellness plan could promote recovery-oriented practice with culturally and linguistically diverse (CALD) consumers of Older People's Mental Health (OPMH services). The consumer wellness plan provides a way for consumers of mental health services to actively participate in their own care by identifying what is important to the person for their individual care and recovery, particularly in terms of symptom management, relapse prevention and crisis planning. Australia has a culturally and linguistically diverse population, with many residents born overseas and originating from non-English speaking countries including refugees, who have a unique and often traumatic experience of migration; therefore, recovery and relapse prevention strategies require understanding of the contextual multicultural differences that arise through cultural and linguistic diversity.

From July 2015 to June 2016, 48% people admitted to the Jara older people's mental health inpatient unit were of CALD backgrounds, most commonly Greek (11%) or Italian (13%). Cultural and language differences can often present as a challenge in a clinical setting where specific cultural issues can act as barriers to staff adopting recovery-oriented practices with CALD consumers.

This project aimed to increase the use of consumer wellness plans among CALD consumers admitted to the Jara older people's mental health inpatient unit who are later discharged to the Camperdown, Concord and/or Canterbury community mental health teams. An increase in the use of consumer wellness plans could assist people to have a more active role in their care and could in turn improve the recovery orientation and experience of CALD people admitted to and later discharged from the Jara unit. It was anticipated that all consumer wellness plans completed as part of this project would also be used to guide each of the consumer's clinical care plans that are developed and followed by the treating clinicians.

Level of consumer involvement in project: Whilst consumers were not involved in the design phase of this project, by its very nature they will be central to the project's implementation and review.

This project sought to conduct a longitudinal clinical follow-up study of people from CALD backgrounds from the Camperdown, Concord or Canterbury local government areas who have been admitted to the Jara older people's mental health unit and participated in developing a consumer wellness plan whilst an inpatient. Eligibility was limited to those who had a RUDAS score of more than 22, were discharged from the Jara unit to a private home with a consumer wellness plan completed, and were also transferred to the community mental health team for follow up and review. Due to challenges in obtaining ethics approval for peer review publication, this project has had significant delays in progressing to implementation.

The project has partnered with the Transcultural Mental Health Centre for assistance with access to language/culturally appropriate clinicians to assist with interpretation and completion of the consumer wellness plan. Alternatively an interpreter will be organised if necessary so that the wellness plan can be completed in partnership with the consumer at a case conference.

Outcomes are to be measured through a 3 month qualitative and quantitative review process completed at 3 months with further measurement will occur via a consumer survey, RUDAS, K10 & discharge documentation. At the same time a qualitative interview will be recorded among a sample of the participants. The currency of the information obtained will be reviewed with the consumer every 3 months or earlier if discharged.

To date, there has been no systematic study of recovery in older CALD consumers. Given the specific mental health vulnerabilities associated with isolation, adjustment to migration and the stigma amongst cultures regarding mental illness, the promotion of recovery-oriented practice is essential in attempting to meet the mental health needs of older CALD consumers. In order to add value to the published literature, this project has sought local ethics committee approval to publish the findings.

Outcome and findings to date

The project team has obtained some baseline data via a consumer survey of current inpatient from CALD backgrounds and people from CALD backgrounds who have been discharged from the unit within the past 12 months.

The challenges in obtaining ethics approval to enable the publication of the project's findings and to move it to the implementation phase were underestimated. Obtaining ethics approval has been the single most challenging part of this project and the ethics approval process for publication significantly delayed project implementation. Due to these delays, the project team opted to proceed with the project without approval to publish. It was important to the project team that they did not allow ongoing delays around ethics approval for publication to derail the project given the high level of need and support the project has within the health service.

Where to now

The project team has sent surveys to 40 CALD patients who have been discharged from the Jara inpatient unit over a 6 month period in 2017 and has conducted two project forums in September and October 2017. The project team is currently organizing a forum to be held in early 2018 to help progress the project further before moving the project into the implementation phase. It is anticipated that ethics approval will follow and that the project team will publish a paper on the project once the project has established findings and is able to add value to the published literature.

Acknowledgements

Ana Zotelo (LHD recovery champion) and Jim Pulious (Supporting manager). We would also like to acknowledge the following people for their contribution to this project Michelle Johnson, Sophie Isobel, Greg Fairbrother, Mariama Mansaray, Ruth Nassari, Maria Gallacher, and the Transcultural Mental Health Centre.

SOUTH WESTERN SYDNEY LHD

Increasing the effective use of wellness plans with consumers of older people's mental health services

Context and project design

The project sought to foster the increased and more effective use of wellness plans within care planning including the identification and documentation of consumer-oriented goals.

Level of consumer involvement in project: As this project focused on staff development with an emphasis on staff education and training related to wellness and care planning processes, there were perceived limited opportunities to involve consumers in the design phase of the project. The project team will be seeking to increase consumer involvement in the design and implementation of follow-on projects.

Most of the documentation on a patient's file is clinically oriented to the treating team's care and treatment plans for the patient. By increasing the effective use of wellness plans, this project aimed to introduce consumer identified goals in language that consumers and carers would understand.

The project aimed to increase completion rates of consumer wellness plans across all OPMH teams and for all completed consumer care plans to have a minimum of one identified consumer goal. These outcomes would be measured by comparing results from audits of consumer files conducted pre and post the introduction of the recovery-oriented training project for OPMH staff the project and the evidence of consumer-oriented goal(s) in the wellness and care plans.

The SWSLHD OPMH Recovery Project involved staff of community teams for Macarthur/Wingecarribee, Bankstown and Braeside. In conjunction with the OPMH recovery training project, training on the use of the wellness plan and integrating consumer-oriented goals took place with all LHD OPMH staff following the identification and training of local OPMH recovery champions. A recovery champion was identified and trained for each OPMH community

team and with other senior clinicians they provided education sessions at district-wide OPMH staff development forums on Recovery for Older People and completion/utilisation of wellness plans.

The project also involved having staff complete the UK Dementia Training Centre 'Recovery and Older people with Mental Health problems' online course, and being provided with access to the NSW OPMH recovery toolkit and related resources. The local staff education sessions on Recovery for Older People and completion/utilisation of wellness plans emphasised completion of consumer wellness plans and the inclusion of consumer identified goals as becoming part of the standard care planning process within SWSLHD OPMH teams. Ongoing support regarding the use of wellness plans was to be provided by recovery champions/senior clinicians.

Outcome and findings

The most recent audit results showed completion rates of wellness plans by staff in a more newly established community team were significantly higher than those for staff within the existing teams who were involved from the commencement of the project. For the new staff, wellness planning was part of their orientation on documentation requirements and they also completed the UK Dementia Training Centre online course as part of their orientation. For staff involved from the start of the project an audit of files for consumers discharged pre and post the education sessions did not show any significant increase in completion of wellness plans but did generally show high rates of consumer involvement in care planning.

This indicated that the education strategy that was designed to increase completion of wellness plans was most effective with new staff where it was part of their service orientation and supported by processes for monitoring implementation. It reinforced that recovery-oriented practice in this area is achievable and underlines the importance of supporting recovery-oriented practice in service model design and education when establishing a new team. It also highlighted that additional strategies are required to support existing staff to implement the required changes in practice to achieve similar results.

Where to now

SWSLHD OPMH service is undertaking a revised strategy to further promote completion of wellness plans and ensure consumer goals are incorporated into care plans. This strategy links that process with two other more recent initiatives being undertaken within the LHD mental health service.

The first is a strengths model project which focuses on strengths-based mental health assessments supported by follow-up individual and group supervision of staff by a senior clinician. The second is a care planning project aiming to improve compliance with the care plan module and increase consumer and carer participation in the care planning process through access to both eMR care planning training and a standardised resource that provides a visual guide to assist compliance. OPMH staff will be assisted by recovery champions/senior clinicians via both individual and group support to integrate processes and practices from each of the projects to deliver improved outcomes in relation to consumer involvement and goal setting guided by and evidenced in appropriate documentation.

The revised strategy including an evaluation process will be registered as a OPMH quality improvement project within the LHD mental health service for completion early 2018.

Acknowledgements

LHD recovery champions Regina McDonald, Cheryl Mitchell and Ruth Ferrington (supporting manager). We would also like to acknowledge the following people for their contribution to this project: Rebecca Malagre; Mardie Cooper; Jennifer Markham; Leena Purathure

WESTERN NSW LHD

Managing our Care

Context and project design

The 'Managing our Care' program is a 6-week group program aimed at supporting consumers living in the community through their recovery journey. The program sought to support consumers by providing education, resources and opportunities for social connectedness. The program introduced consumers to the 'My Guide' resource which was developed by the Transition to Care Steering Group at Bloomfield Hospital. The 'My Guide' provides consumers with the opportunity to complete a recovery focused wellness plan.

The 'Managing our Care' program was designed as a referral point following a consumer's discharge from inpatient care into the community from the older people's mental health unit at Bloomfield Hospital.

Level of consumer involvement in project:

Consumers were central to the process of providing feedback about the 'My Guide' resource and in driving revisions to the managing our care program as the project developed and grew.

The 'My Guide' resource is a new resource not specifically targeted at the OPMH population and therefore reviewing the resource and adapting it for older consumers of mental health is one of the aims of this program.

Managing our Care introduced a post-discharge community based, consumer driven recovery-focused group program specifically for older consumers of mental health services. This program considers the nuances of recovery-oriented practice for older consumers and aims to:

1. Encourage consumer-driven care
2. Be goal oriented, including the completion of the 'My Guide'
3. Promote an increased awareness of recovery focused care through education and group discussions

The program delivered weekly one and a half hour group sessions over a six week period with the target cohort of consumers. These sessions provided consumers with information, mental health education and an opportunity to develop their own wellness plan as part of completing the 'My Guide' consumer wellness resource.

The project aimed to ensure that OPMH consumers across the Orange local government area in regional central west NSW had access to this group. To assess project outcomes, the RAQ16 was utilised to measure consumer recovery pre and post-program participation. Participants also provided consumer feedback regarding the 'My Guide' resource to ensure the resource meets the need of the OPMH population group.

Outcome and findings

Qualitative findings from the 'Managing our Care' program were very positive and demand for the program increased over the pilot period. Consumers reported that the program fostered new friendships and developing effective coping mechanisms post-discharge from inpatient care. Consumers reported that they found the 'My Guide' to be a useful reflective tool, providing a reminder of useful strategies to improve wellness and to access supports as needed.

In reviewing the evaluation responses, it was not possible to draw statistically significant conclusions from the RAQ 16 data due to the limited number of participants in the pilot. However, results did indicate that participants had a good understanding of the recovery process. Qualitative feedback from consumers was overwhelmingly positive and warranted a review of the project with a view to expanding it to other areas within the LHD.

Where to now

Following the initial pilot and review of the program in Orange NSW, it was successfully expanded to other areas within the WNSW LHD including Parkes NSW. Expanding the project to other areas within the local health district will help with further developing the pool of quantitative data to support future project directions.

In addition to expanding the program to other areas, the review also recommended that the project team continue using the materials, tools and structure as originally developed and that the 'My Guide' manuals are also followed up as part of caseworker support in the community.

Acknowledgements

OPMH recovery champions Kristen Szulik and Zita Spicer, and Ian Rawson (supporting manager). We would also like to acknowledge the Transition to Care Steering Group at Bloomfield Hospital for their contribution to this project.

Real choices

A central tenet of the recovery model is to support people's decision-making and respect their choices about their mental health treatment and recovery. Recovery-oriented mental health practice should support and empower individuals to make their own choices about how they want to lead their lives and acknowledge the consumer's choices in a way that is meaningful and creatively explored. Giving consumers of mental health services real choices should support individuals to build on their strengths and take as much responsibility for their lives as they can whilst ensuring that there is a balance between the duty of care and support for individuals to take positive risks and make the most of new opportunities.

Services must not assume that clinicians understand and deliver person-centred or recovery-focused care, but develop clinical and organisational processes which:

- support a shared understanding by the patient, carer and treating team members of key aspects of the 'person';
- develop collaborative care partnerships;
- strive for the 'recovery' desired by the patient and their carers;
- encourage monitoring and measurement of progress towards agreed treatment goals.

McKay et al (2015)^{vii}

ILLAWARRA SHOALHAVEN LHD

Re-orienting staff to recovery-oriented practice through education and introducing collaborative care planning practices

Context and project design

This project delivered foundational recovery training to OPMH staff who work within the Local Health District older people's mental health services. The training delivered was based on resources found in the OPMH recovery-oriented practice improvement toolkit. The training for this project was rolled out in conjunction with introductory training on collaborative care planning. The project sought to assess if implementing recovery training alongside the implementation of collaborative care plans had an impact on staff attitudes towards recovery and actual changes in practice.

Level of consumer involvement in project: The level of consumer involvement in this project was limited. The videos and training materials developed for this project featured clinical staff. The project team will be looking at how they can better involve consumers in future recovery-focused projects.

The project aimed to improve the knowledge and use of recovery principles and language among older people's mental health staff with a view to also increasing staff engagement with consumers and the adoption and use of collaborative care planning.

This project undertook an initial baseline file audit to assess consumer involvement in care planning within the local inpatient and community older people's mental health teams. Following establishing a baseline assessment of consumer involvement in care planning, a basic recovery training module was developed utilising the material in the UK training package and the OPMH recovery-oriented practice improvement toolkit. Additionally, the project piloted collaborative care planning with consumers by adapting previous care planning documentation to incorporate recovery-oriented practice goal setting and consumer engagement. At the end of the pilot period, the files were re-audited to assess the impact of the project.

Outcome and findings

Baseline audits of consumers' files from the inpatient and community OPMH centres were undertaken, examining a total of 60 files for a period of five months. The baseline audit found that less than 35% of consumers in the service participated in their care planning. Furthermore it was noted that less than 10% of consumers were consulted regarding their care planning.

In developing a local training module it was initially agreed to develop role-play scenarios that could be used as a training tool with staff, however due to staff turnover and shift work, it was identified early on that this method would be difficult to train staff (particularly nursing). It was also noted that environmentally it is very difficult to educate staff during working hours as some must remain 'on the floor' to care for consumers. After further consultation it was agreed that the role-play scenarios would be recorded and used as educational training videos on recovery targeting nursing, medical, and allied health staff.

Audits were conducted following the development and rollout of the training videos to staff.

| Measure | Before training (May-September 2016) | Following training (March – July 2017) |
|--|---|---|
| Identified strengths of the consumer have been noted in their clinical file | 7.5% of files audited | 52.5% of files audited |
| Consumer involved in the care planning has been listed in their clinical file. | 52.5% of files audited | 92.5% of files audited |
| Consumers needs assessment documented in clinical file | 42.5% of files audited | 87.5% of files audited |
| Self-report k10 had been completed with consumer | 15% of files audited | 82.5% of files audited |

The project found a mean improvement of 47.5% in consumer participation in care planning. It is expected that by December 2017 over 90% of consumers of the service will be participating in their care planning.

Where to now

Given the success of the project, the instructional training videos have become part of the orientation programs of all new local health district mental health staff. The project team are also planning to expand their project by producing other ‘homegrown’ videos pertaining to clinical care, eg how to complete a wellness plan or how to coordinate a family meeting.

Acknowledgements

LHD champions Stephen Young and Eddie Zeballos, Peter Pulcini (supporting manager). We would also like to acknowledge the following people for their contribution to this project: David Hughes, Irene Constantinidis, Peter Brown, Dr Daryl McMahon, Liliana Ruti, Eddie Barry, Greg Rigby, Tim Coombs, Joanne Dwyer, and Carol Martin.

MURRUMBIDGEE LHD

Involving consumers and carers in developing wellness plans and recovery goals in care plans

Context and project design

The aims of this project was to increase Murrumbidgee LHD’s OPMH community clinicians understanding of recovery-oriented practice by having them complete the UK online training and participate in a teleconference to discuss the local relevance of recovery to their practice; to provide MLHD’s OPMH community clinicians with support in the development of care plans with the target that at least one goal is developed collaboratively with the consumer and/or carer; to improve the overall effectiveness and use of wellness plans that inform

care planning; and to develop and improve documentation processes in relation to recovery-oriented consumer goals within the consumer’s clinical file and care plan.

Level of consumer involvement in project: The level of consumer involvement for the project was limited for this stage of the project, with the focus being on staff education. Increased consumer involvement is planned for the next stage of this project.

This project sought to have all LHD community OPMH staff to complete the UK on-line training ‘Recovery Focused Practice in Older People’s Services’. The project conducted a pre and post-test of staff attitudes towards recovery using the STARS measure. A baseline audit of care plans before education and after education was completed to assess the impact of the training. An audit of consumer care plans was also conducted to identify the proportion of consumer care plans that had consumer identified goals.

Before undertaking the project, the proposed project was discussed with OPMH clinicians, clinical leaders and team managers to garner support for the project. It was identified early on that the main challenge for staff will be changing practice to include the consumer and/or carers to develop recovery-oriented care plan goals. In consultation it was agreed that staff need to develop confidence and skills in the use of the wellness plans and the role of a wellness plan in care planning. For managers and clinical leaders the challenge was to ensure that progress was monitored and reviewed on a regular basis against the project goals.

Outcome and findings

The project was successful in getting all staff to complete the online training. Pre and post STARS questionnaires indicated high scores with no significant difference, suggesting that staff had a relatively firm understanding of the concepts of recovery prior to undertaking the training.

There were a number of challenges in conducting clinical file audits due to the geographical distances between sites. Challenges in conducting file audits were heightened by differences in file systems between sites with some using paper files whilst others were transitioning to electronic file systems. Despite these challenges it was noted that the HoNOS65+ outcome measures for all consumers could be better used to inform care planning and that a process could be implemented to use consumer wellness plans to inform clinical care planning.

This project successfully initiated practical discussions across the local health district around recovery-oriented practice with older consumers of mental health services.

Where to now

In reviewing the project at the local level it was agreed that a forum would be held to progress the initial goals of the project and to expand its scope. The forum plans to include participation by consumers and carers, OPMH clinicians and team leaders as well as the districts specialist adult mental health rehabilitation and recovery teams as a more collaborative approach across the age spectrum may be helpful, particularly with clinicians who work across multiple teams.

Acknowledgements

Joy Howell (LHD champion) and Pamela Brinsmead (supporting manager). We would also like to acknowledge the following people for their contribution to this project: Alison Thorne and Samantha Pearce.

Attitudes and rights

Recovery-oriented mental health practice involves listening to, learning from and acting upon communications from the individual and their carers about what is important to the individual whilst promoting and protecting their individual legal, citizenship and human rights. Clinically, recovery-oriented practice should support consumers of mental health services to maintain and develop social, recreational, occupational and vocational activities which are meaningful to them and instil hope in an individual about their future and ability to live a meaningful life.

Viewing recovery as a normal human process 'demystifies' the process of recovery from mental health problems and puts people in a better position to support someone in their recovery journey.

NSW Mental Health Coordinating Council (2008) ^{viii}

NORTHERN SYDNEY LHD

Measuring the Recovery Attitudes of NSLHD OPMH Clinical Staff

Context and project design

It has been demonstrated that a recovery-based training program for clinicians can enhance clinician attitudes towards recovery (Crowe et al, 2006; Psychiatric Services 57; 1497-1500).^{ix} This project aimed to replicate this in Northern Sydney LHD using a OPMH- specific recovery training program, while at the same time engaging in capacity building and recruiting local recovery champions. The project team also aimed to demonstrate the utility of completing an education program over routine systemic awareness-raising or social desirability reflected in the questionnaire completion.

Level of consumer involvement in project: There were limited opportunities for consumer involvement in this project. However the project team will be looking at how to better include consumers in future recovery-focused projects.

This project aimed to facilitate the development and implementation of recovery-oriented practice across NSLHD OPMH. Furthermore this project sought to demonstrate a change in recovery attitudes and knowledge following completion of the program compared with routine education and training.

In partnership with Macquarie University PACE students this project engaged a wide range of NSLHD OPMH clinicians to undertake the Dementia Training Centre 'Recovery and Older people with Mental Health problems' online course. The project aimed to have a control group of 20 clinicians who did not complete the training and an experimental group of 20 clinicians who did complete the training. Staff in both groups then completed a pre and post-test recovery knowledge inventory to measure any increase in recovery-oriented practice skills & knowledge in the experimental group.

Outcome and findings

40 NSLHD OPMH clinical staff who had not completed the Dementia Training Centre 'Recovery and Older people with Mental Health problems' online course were recruited for the project and divided into two groups of 20 clinicians. Of those recruited 38 clinical staff completed the Recovery Knowledge Inventory (Bedregal et al^x) as a pre-test measure of recovery knowledge skills and attitudes. 31 staff completed the 4-week post-test Recovery Knowledge Inventory, however complete data was only available for only 29 participants (Control n = 15, Experimental n = 14). The project found a modest significant result for the experimental group, noting that there was a lack of statistical power given relatively small sample size.

The project found that there was an overall increase in knowledge of recovery principles for the experimental group but the level of training could be too basic for experienced OPMH clinical staff. The project found that there was a good level of pre-existing knowledge of recovery principles and person-centred care amongst OPMH clinical staff in NS LHD.

Where to now

Anecdotally clinicians have provided feedback that they enjoyed the opportunity to be in the study and it was a valuable exercise in engaging busy frontline clinical staff across a variety of disciplines in discussing how we collectively work within a recovery context.

Overall 75% NSLHD OPMH staff have now engaged in training in recovery principles and the project has started a discussion locally about recovery-oriented practice with our cohort of consumers.

A follow-up study is currently underway in NSLHD OPMH again working in partnership with Macquarie University PACE students. The study involves utilising a mixed methods approach to an understanding of how Collaborative Care Planning is utilised across OPMH Inpatient and community teams as well as some of the barriers and enabling factors.

Acknowledgements

LHD recovery champions Stephen Kay, Brooke Richards and Khima Neure. Supporting Managers Julie Strukovski and Andrew Clement. We would also like to acknowledge Associate Professor Carmelle Peisah for her contribution to this project.

Dignity and respect

Recovery-oriented mental health practice involves being courteous, respectful and honest in all interactions and involves sensitivity and respect for each individual, especially for their values, beliefs and culture. Recovery-oriented practice should challenge discrimination wherever it exists within our own services or the broader community, within an older people's mental health context this includes challenging ageism and allowing dignity of risk.

Recognising that consumers' self-determination is a vital part of successful treatment and recovery, the principles of recovery emphasise choice and self-determination within medico-legal requirements and duty of care. Striking a balance requires an understanding of the complex and sometimes discriminatory nature of the goal of reducing all harmful risks.

A national framework for recovery-oriented mental health services: guide for practitioners and providers (2013 p.3)ⁱⁱ

CENTRAL COAST LHD

OPMH peer workforce

Context and project design

Peer work facilitates a level of understanding, support, acceptance, hope and a belief in recovery that comes through sharing personal experiences of living with and overcoming mental health issues.^{xi} This mutuality helps to alleviate the alienation and loneliness associated with having a mental health issue or mental illness.^{xi} As evidence increasingly shows, peer work is effective in supporting people's recovery from mental illness,^{xii} integrating peer work into health systems is now at the heart of national and international reform agendas in mental health,ⁱⁱⁱ and this project sought to expand the current body of evidence.

Level of consumer involvement in project: In the project planning phase the project was informed by OPMH consumers via two community-based focus groups. OPMH consumers provided advice as to what the role of peer workers should be and advised that older peer workers should be aged 50 years and older to ensure they were able to engage with consumers around a lived experience of mental illness and ageing. The project team engaged in a process of co-production with peer workers and OPMH clinicians in the design, development and

evaluation phases of the program to ensure the peer work model met the needs of all stakeholders.

Historically consumers and carers of Central Coast OPMH have had no access to peer workers in the community setting, with consumer consultants employed within mental health focusing on adult services only (which excludes older people) and the inpatient setting. This project aimed to establish a peer work model to meet the needs of older consumers of OPMH. To the best of our knowledge, the peer work model this project has developed is the first to meet the specific recovery needs of older people who experience mental illness.

The Central Coast Specialist Mental Health Services for Older Persons (CCOPMH) received a 12-month funding grant from Central Coast Primary Care (CCPC) to design and implement a model for a peer-based, recovery service for older people, delivered by older people. Central Coast OPMH clinicians and CCPC recruited and trained a pool of older peer workers (aged 50 years and over) who had a lived experience of mental illness and ageing. The minimum age limit of 50 was determined through consumer consultation forums where a significant proportion of consumers indicated that peer workers working with older people should be mature of age, over 50, as it was felt that peer workers working with older people should also have personal experience of ageing not just a personal experience of mental illness. Peer workers were recruited through advertising in local media and community organisations/services. The project found that the recruitment approach was an effective approach and that the minimum age limit helped make the consumer workers more relatable to older consumers in the service.

Central Coast OPMH received funding to provide training and education to recruited peer workers e.g. the MHCC Certificate IV in peer work,^{xiii} Mental Health First Aid Course,^{xiv} and the OPMH specific online Recovery Training. Once recruited and trained peer workers were employed on a casual basis for a 12 month period with a focus on the provision of personal recovery services such as peer support, wellness planning, and recovery groups. Peer workers also provided education regarding older person's mental health to a range of community service providers.

A range of methods were used to systematically monitor and reflect on the model development and outcomes (Koshy et al., 2011).^{xv} In particular, the evaluation predominantly used qualitative methods and consisted of the following,

- Four focus groups with recruited peer workers (n= 4-6) at key points throughout the pilot project i.e. at recruitment, and then quarterly.
- Individual interviews with peer workers at the midpoint and at the completion of the 12-month project.
- Surveys completed by consumers who have received services from the peer worker service
- Examination of project information/document review
- Field notes
- Focus group with other stakeholders/steering committee

Outcome and findings

Following an advertising campaign to recruit peer workers the project team successfully recruited 7 candidates. Preliminary findings indicate that older persons are well suited to the provision of peer work. This has been conceptualized as, in part, due to their age and maturity and as such some of the barriers to implementing peer work models in mental health settings identified in the literature are less prominent for the older peer group population. Under the current model peer workers are successfully co-facilitating a 4-week group recovery program, individual recovery sessions with OPMH consumer and carers, providing community education about recovery for older people and participating in systematic advocacy and consultation.

'I feel like a little stone that's thrown into a pond and I'd would love to know the ripples it will cause the program for each of us and I'm sort of adding up how many people's lives we may have affected and how many people I've met who would love to be part of it, so it is exciting.'

Central Coast LHD peer worker

The project has found that older peer workers bring a wealth of knowledge, patience, understanding and good judgment to the role. One of the key challenges for the peer workers was undertaking the certificate IV in peer work and thus has caused the project team to consider what training older peer workers requires. The peer workers did require support with the certificate IV in peer work and the time investment on staff to provide this support was underestimated at the project development stage but has been well managed.

Of the key barriers to the implementation of peer models reported in the literature was resistance from staff was a consideration for this project. While implementation was faced with some resistance from staff, this was managed through providing clinical staff with training regarding the rationale, role and benefits of peer work. Key questions staff asked within the context of barriers included role clarity, concerns regarding competency and trust, concerns about the mental health of peer workers and concerns about policy and procedure.

Where to now

The introduction of peer workers has been very successful and they have become a valued part of the service. Future plans for the project include recruiting more peer workers, reviewing the training needs of older peer workers and seeking sustainable sources of funding for the project so that older peer workers become part of the standard workforce in the service long term.

Acknowledgements

LHD recovery champions Sharon Kakato and Grace Ongley, supporting managers Raichel Green and Dr John Dobrohotoff. We would also like to acknowledge the following people for their contribution to this project: Central Coast Older Peer Workers, Patrick Livermore, Dr Dominiek Coates, Patricia Lenan, and Cheryl Jones.

ST VINCENTS HEALTH NETWORK

Club HARP

Context and project design

The 'Club HARP' project is a group program aimed at consumers of the St Vincent's psychogeriatric and Dementia Service. The objective of the program was to provide an opportunity for consumers to participate in an informal, holistic, health promotion, psychoeducation, peer support, recovery focused group. It was intended that by design, the exact content of the program would be consumer driven.

The program sought to provide education, community, and psychoeducational resources and peer socialisation opportunities.

Level of consumer involvement in project: While the design of the project did not involve consumers, the intention was that the exact content of each session would be consumer-driven.

Club HARP sought to run a consumer driven recovery-focused group specifically for older consumers of mental health services, taking into account the nuances of recovery-oriented practice for the older cohort of consumers. The project aimed to:

1. To initiate a recovery focused group which is driven by consumer need and interest
2. To provide usable and practical resources
3. To bridge a current gap in service provision

The program established small groups, participants recruited through the St Vincent psychogeriatric and Dementia Service and participated in ten weekly consumer-driven group sessions.

These sessions were designed to be informal, holistic, fostering peer support whilst offering health promotion and psychoeducation.

A Montreal Cognitive Assessment (MoCA) was completed before the intervention to ensure the consumer meets the inclusion criteria of nil to mild cognitive impairment. Evaluations were also completed by the group participants after each session. The project settled on a small number of measures including the Geriatric Depression Scale (GDS), The World Health Organization Quality of Life (WHOQOL – BREF), and a Functional Status Questionnaire. The project was assessed via participants completing a self-report measure (the Recovery Self-Assessment RSA-41), pre and post-intervention.

An ethics application has been submitted so that the findings of this project can be published.

Outcome and findings

All clinicians, in particular, nursing staff, have embraced this project and have displayed enthusiasm regarding the potential benefits for consumers, and also for clinicians involved.

The project successfully implemented small groups of 7 consumers for one 90 minutes group session per week for a period of ten consecutive weeks. Participants were provided with folders to keep their weekly content.

Club Harp weekly topics

1. Welcome – Meet and Greet
2. Healthy Brain Ageing
3. The Pursuit of Wellness
4. Healthy Eating
5. Staying Healthy and Active
6. Relapse Prevention
7. Maintaining Independence
8. Social Supports
9. Future Planning
10. Recap – Closing

Where to now

Following the initial pilot phase, the project was reviewed for feasibility and changes were identified. The group program model resulted in very strong engagement with each topic presenter and an eagerness to learn, with consumers exhibiting a lot of enthusiasm around the new skills developed from the program. Consumers identified in feedback that these kinds of group programs were very helpful in fostering peer support and allow new friendships to blossom.

A key consideration in the review was that participants asked for involvement in other group programs facilitated by our team.

Consumer feedback in conjunction with reviewing evidence-based information regarding recovery in the older population will guide future Club Harp programs in 2018.

Acknowledgements

Jennifer Kelly (LHD recovery champion) and Dr David Burke (supporting manager). We would also like to acknowledge the following people for their contribution to this project: Dr Kate Mullin, Katie Friel, Kate Green, Rebecca Sarkies, Emma Carey, and Danielle Gately.

Partnership and communication

Recovery-oriented mental health practice acknowledges that each individual is an expert on their own life and that recovery involves working in partnership with individuals, their carers and the community to provide support in a way that makes sense to them. For clinicians, recovery-oriented practice encompasses the value of sharing relevant information and the need to communicate clearly and involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations. For older consumers this partnership often includes supporting the consumer to regain their pre-existing identity or 'continuing to be me'.

Central to recovery for older people is the significance of an established and enduring sense of identity, and all described, in detail, the history of their lives before becoming unwell. The journey of recovery from mental illness appeared primarily to be connected to the extent to which the pre-existing sense of identity could be maintained or regained.

Daley et al (2013)ⁱⁱⁱ

The Road to Recovery project utilised the standard wellness plan pro forma to be completed over four group sessions co-facilitated by a OPMH clinician and a OPMH peer worker.

To assess the success of using peer workers as part of the Road to Recovery project all consumers and carers who attend were provided with an evaluation survey.

Outcome and findings

Consumers who attended the program rated the program very highly with 90% indicating the group was extremely useful. They did not however find the wellness plan document useful and recommended a simpler recovery goal-setting document be used. An unexpected benefit for consumers of the program has been the social connections consumers made with each other that have continued following the group programs completion with many consumers maintaining contact with each other post group. The co-facilitation model of peer workers and clinicians was also instrumental in assisting clinicians to develop relationships with older peer workers and develop trust and confidence in their abilities as part of the implementation of the wider peer worker project.

Where to now

As a result of feedback from the project, the standard wellness plan proforma was removed from the content of the program. Completion of wellness plans has not increased as per the original goals of the program, alternatives to the wellness plan will be considered in future revisions to the program.

Acknowledgements

LHD recovery champions Sharon Kakato and Grace Ongley, supporting managers Raichel Green and Dr John Dobrohotoff. We would also like to acknowledge the following people for their contribution to this project: Older Persons Peer Workers, Patrick Livermore, and Central Coast OPMH Clinicians.

CENTRAL COAST LHD

Road to Recovery

Context and project design

The Road to Recovery project aimed to cater to the recovery needs of older consumers of mental health services through group sessions that were co-facilitated by a clinician and a peer worker. The group focussed on introducing recovery concepts to consumers and carers and assisting consumers to identify and implement recovery goals over 4 group sessions.

Completion of wellness plans within the Central Coast OPMH service is very poor with clinicians not placing value on the completion of this document with consumers. The group program aimed to increase the completion rate of wellness plans.

Level of consumer involvement in project: This project involved consumers at every stage of its development and implementation. Consumer involvement in this project was transformative, the roads to recovery project continues to be co-facilitated with peer workers.

WESTERN SYDNEY LHD

Blacktown OPMH: Early Wellness Planning Context and project design

This project sought to introduce the 'Mental Health Consumer Wellness Plan' earlier in the assessment process by providing it to consumers of the Blacktown community OPMH service with the services welcome pack that is provided at the initial assessment. The project team hoped that by moving the wellness plan to earlier in the consumer's journey with the service, that this would potentially provide an improved perspective of the client's goals and skills that could be used to better develop their care plan.

Consumer wellness plans are currently underutilised in Western Sydney LHD OPMH services. By refocusing the use of the wellness plans the project team hoped to make the consumers care plans more consumer-focused and recovery-oriented. It was intended that this project would facilitate a greater recognition of the consumer's strengths and existing supports when planning their care with the service.

Level of consumer involvement in project: There were limited opportunities for consumer involvement in this project. However the project team will be looking at how to better include consumers in future recovery-focused projects.

This project aimed to consistently encourage the completion and use of wellness plans with consumers of the Blacktown OPMH community mental health service with a view to promoting consumer empowerment, and an increased focus on the consumers goals in care plans.

One challenge identified in the approach undertaken by this project was if all consumers had the capacity to complete the wellness plan themselves. To address this the project team ensured that each consumers care coordinator offered assistance and also liaised with a family member or carer if the consumer preferred that their family member or carer assisted them with their wellness plan. The project team noted that clinical judgment would be required to determine when implementation may not be appropriate as some consumers will have a limited capacity to participate in developing their wellness plan.

The project sought qualitative feedback from consumers and their carers about the wellness plan during the initial contact. This was followed up with the consumer and their carer 3 months later or during discharge from the service.

Outcome and findings

The project was successful in starting conversations about recovery and wellness planning in the service. Staff have become more engaged in wellness planning with consumers as part of the initial contact with the service. A file audit was completed to assess the success of the project, the audit revealed a modest improvement in the adoption of wellness planning and the inclusion of consumer goals in care plans.

Where to now

Following a file audit, it was identified that there was further room for improvement regarding the adoption of wellness planning and the inclusion of consumer goals in care plans. Qualitative feedback from staff about wellness planning and the inclusion of consumer goals in care plans has become part of the service's monthly team meetings as a means to monitor and improve wellness plan completion rates and the use of consumer goals in care planning.

As a next stage of the project, a Consumer Wellness Plan Outcome Measurement Survey, has been developed and implemented. Data from this survey has helped inform clinicians on how they can improve their practice in relation to wellness planning and including consumer goals in care plans.

Acknowledgements

LHD recovery champions Dayle Tierney and Suellen Haskins, supporting managers: Dr Suman Tyagi and Skirma Cervin. We would also like to acknowledge the following people for their contribution to this project: Ms Shalini Chandra and the Blacktown teams' involvement in the project.

Evaluating recovery

Recovery-oriented mental health practice ensures and enables continuous evaluation at several levels. At one level recovery-oriented practice should enable individuals and their carers to track their own progress, whereas it should also allow the service to demonstrate that they use the individual's experiences of care to inform quality improvement activities. At a tertiary level it should also enable the mental health system to report on key outcomes that indicate recovery. These outcomes include housing, employment, education, social and family relationships, health and wellbeing. Evaluating recovery presents some unique challenges for services as well as unique opportunities to reassess not only how we measure outcomes and the work that we do, but also in the methods and approaches we take in the evaluation process itself.

The concept of 'recovery' in mental health is broad and complex, and creates a challenge for data development and measurement. Most definitions of recovery emphasise that it is a process rather than a state or endpoint.

Measuring recovery in Australian specialised mental health services: a status report (2015 p.1)^{xvi}

SOUTH EASTERN SYDNEY LHD

The evaluation of the eastern suburbs mental health service's older person's recovery suite

Context and project design

Over 12 months the Aged Care Psychiatry Department, Prince of Wales Hospital piloted a suite of recovery-focussed activities for older people. This project sought to conduct a qualitative evaluation and needs analysis to ensure that the 'recovery suite' addresses the needs of older people, identify any gaps and inform further service developments appropriate to older people.

The development and implementation of the programs within the SES LHD older person's recovery suite are innovative and recovery focused to provide older consumers with the ability to

regain their own confidence and independence. These programs provide an opportunity for individual and group settings to liaise with peers and professionals, to set goals and to achieve as well as develop social relationships and activities.

Level of consumer involvement in project:

Consumers have been involved in the review of the suite of recovery programs. They were involved collaboratively in the initial phases of the development of the programs as well as providing feedback during and after each session. Their feedback shaped further development of the programs. Consumers have also been involved in the qualitative analysis of the programs.

Evaluation of the SES LHD old person's recovery programs was crucial in considering the efficacy of these programs as well as to inform the further development of these programs to better meet the needs of the consumers during their recovery journey. To date there has been no formal evaluation of the recovery suite of programs or whether they are meeting the needs/goals of the services consumers.

The initial stage of evaluation of the *recovery suite* involved a qualitative evaluation to consider any shortfalls of the programs as well as any barriers to implementation to these programs. For instance, it had already been identified that availability of transport is sometimes a barrier for consumers to attend hospital-based outpatient recovery programs. The evaluation process enabled further consideration of the barriers to the attendance of these programs and for problem-solving to provide solutions.

The suite of recovery programs has become an advantageous part of the services provided by Aged Care Psychiatry service at Prince of Wales Hospital. Further evaluation and developments of these programs will help strengthen the resources available to the older adults to develop confidence, maintain independence, and continue to be the people they're meant to be.

There are eight programs in the current suite of programs that will be reviewed as part of this project.

The project aimed to:

- a. Conduct a needs analysis of consumers and carers of the Aged Care Psychiatry Service, Prince of Wales Hospital to identify gaps in service delivery and to identify barriers that inhibit inclusion in the existing programs
- b. Consult with partner organisations and groups (e.g. local councils, aged care service providers) who belong to the Older Persons Mental Health Working Group (a group convened by Aged Care Psychiatry and a recent recipient of a NSW Association of Mental Health award) regarding opportunities to further develop recovery-oriented services including issues such as transport and activities.
- c. Evaluate the pilot Eastern Suburbs Mental Health Service Recovery Suite using tools proposed by the OPMH Recovery Practice Improvement Project (two members of the Aged Care Psychiatry team, Cathy Ebert & Jacki Wesson, are involved with this project and are nominated 'recovery champions')
- d. Utilise feedback to inform future service planning
- e. Provide information to the Recovery College of the needs of older people & service providers working with older people in order to develop appropriate modules for staff and consumers.

The Euroa Well-Being Group

This program commenced in 2010 as a combined initiative of social work & diversional therapy. It is an open weekly psychosocial support group with the aim of creating a supportive and comfortable environment in which group members can socialise, share experiences and reflect on a broad range of issues. This program also seeks to create a step-down from hospital admission that gently integrates members into social and community activities whilst providing psychoeducation on a range of lifestyle topics relevant to members, such as exercise, relaxation, diet and medication. The wellbeing groups aimed to improve members' confidence and self-esteem where these may be lacking due to mental health concerns, isolation, change in cognitive/physical abilities, cultural barriers or change in lifestyle.

The Euroa Occupational Therapy Recovery Group

This is a pilot occupational therapy group that commenced in 2014. It is a closed group with 8 weekly sessions over 2 months. It has the following aims:

- Support understanding of the recovery process and contextualising recent illness
- Facilitate development and implementation of individual consumers' recovery process
- Identification of personal strengths, abilities and skills which promote recovery
- Provide an environment where skill building is encouraged and facilitated
- Personalised strategies discussed in a group setting to facilitate optimal participation in consumer identified activities and situations

- Reduce functional disability and further disengagement
- Increase carer skills in facilitating open discussion of 'tricky' subjects, and helping consumers engage in specified activities including problem-solving, communication, and simplifying tasks.

The Euroa Emotional Recovery Program

This is a 4 session pilot program that commenced in August 2014 and is led by a clinical psychologist and diversional therapist to facilitate recovery in an inpatient old age mental health setting. It has been developed for people with serious mental disorders complicated by mild cognitive impairment and is informed by Dialectical Behaviour Therapy. It comprises individual and group sessions to assist in emotional recovery. The sessions of the program focus on understanding emotions and mindfulness, expressing effective communication, encouraging self-talk around emotions, and distress tolerance and emotional regulation.

Qualitative and quantitative data has been gathered from each session and the completion of the 4-week program.

The Euroa Volunteer Program

For many years Aged Care Psychiatry has had involvement of volunteers – mainly carers or consumers – and they have been involved in two ways – direct support of patients on the ward, such as by assisting with the BBQ & hairdressing, or by participation in our consumer's committee that has been organising the annual mental health promotion forum and overseeing the consumer satisfaction surveys. Deaths and poor health of a number of members led to the commencement of a recruitment

drive under the leadership of the social work team in 2013. This is an ongoing process. One arm of the volunteer program is to provide an opportunity for recovery through volunteering.

The Care Adapt Program

This is a three to four session Pilot Program for people transitioning/adjusting to home or a Care Facility (Hostel or Nursing Home). A Clinical psychologist provides 1:1 contact with the client as well as with carer/staff/family member for two sessions. The third session is a telephone call to the carer/staff/family member to assess how the program is being implemented and to provide them with support to reinforce the program and skills. This program is informed by dialectical behaviour therapy and focuses on providing the client with validation about their issues/concerns as well as providing psychoeducation on understanding emotions, emotional expression and mindfulness; and encouraging self-talk around emotions and distress tolerance/pleasant activity scheduling.

ABILL program

The Adjustment and Brief Intervention for Later Life Program is a four-week DBT based recovery program for older adults to develop skills to regulate their emotions and learn distress tolerance skills. This program also focuses on developing goals for the clients to achieve that may contribute to their confidence and maintaining their independence.

The Euroa Nutrition Group

This is a pilot program that has been trialled in the well-being group and so far has consisted of four presentations on nutrition.

GOALS Program

The GOALS Program is Goals for Older Adults and Life Skills. This is a Mindfulness-Based CBT Program for older clients with anxiety and depression. The program is 8 weekly and has been developed for outpatients who are experiencing symptoms of anxiety and depression. Clients with Mild Cognitive Impairment are also supported in their recovery process within this program. The program focuses on facilitating the development of skills for the clients to cope adaptively with their current symptoms. The aim is for clients to set goals and develop confidence in their lives despite their current symptoms. The group setting aimed to provide socialisation with other clients to provide an atmosphere of supportive problem about life issues with age-related peers.

Outcome and findings

The evaluation highlighted the success of the programs currently being utilised within the current suite of programs. Consumers highlighted the importance of connectedness and socialisation and that the programs assisted them with reduced loneliness, increased relationships, increased confidence and enjoyment from activities, beneficial mindfulness and exercise components, empowerment with medication management, hope and recovery from trauma, increased responsibility with encouragement in activities e.g. gardening, and a sense of 'wanting to give back'.

From a staff perspective, the recovery team members highlighted the importance of planning and working with consumers for their recovery noting that recovery allows for therapeutic relationships to exist and the need to ensure that the programs are identifying and enhancing the consumer's individual strengths.

Where to now

Future plans for the evaluation process for the suite of programs includes further evaluation of consumer wellness plans, evaluating recovery language and expanding the availability of peer support with a potential project around employing older person peer workers.

Acknowledgements

LHD recovery champions Cathy Ebert and Jacqueline Wesson, supporting managers Dr Brian Draper and Liz Abbott. We would also like to acknowledge the following people for their contribution to this project: Julie Sleeman, Daniella Kanerack, Natalie Narunsky, and Justine Finlay.

HUNTER NEW ENGLAND LHD

Recovery-oriented linguistic analysis of Collaborative Care Management Plans

Context and project design

This project set out to conduct a linguistic analysis of collaborative care management plans utilised by older people's mental health services in Hunter New England LHD. The analysis sought to critique the care management plans for expression which is potentially labelling, disempowering or judgemental and promote more recovery-oriented language to support recovery-oriented practice.

Level of consumer involvement in project: A consumer and a carer consultant worked directly in partnership with the LHD champion (a mental health clinician) for this project. Collaboratively they identified the stigmatising language in care plans, giving the project a very strong consumer and carer voice.

Clinical documentation in consumer files continues to be clinically focused. In proposing this project it was felt that *collaborative care management plans* should be more recovery-oriented, given that the consumer collaborates on the content of these plans. This project sought to identify key linguistic issues in the current plans, and to develop a set of model plans with recovery-oriented language to help guide clinicians in how to use more appropriate language when developing collaborative care plans in the future.

In conjunction with a consumer consultant and a carer consultant, the clinician leading this project jointly reviewed and identified the language in existing care plans for older consumers. This was conducted via a file audit and an analysis of commonly used language that is potentially labelling, disempowering or judgemental, with a view to quantifying examples of poor expression.

Outcome and findings

The initial audit included 22 patient care plans which were audited in consultation with both a consumer and a carer representative. The project identified the outdated language as part of this audit. Based on the identified language, model management plans and educational resources were developed to re-orientate clinical staff to recovery-based language for consumer care plans. Training was delivered in four face-to-face presentations with resource materials in the form of a linguistic guide for completing collaborative care plans distributed to staff as part of the training sessions.

Following the introduction of the linguistic guide/ model plans to help guide improvement in the language, the model plans were used to audit clinical files post-development as a proxy measure to assess if there had been an improvement in the language used in collaborative care plans. Care plans for the same 22 consumers were audited before and after the adoption of the linguistic guide and rollout of the training. The project found that the number of inpatient collaborative care plans with non-recovery based language in care plan reduced from 12 to 7 (chi-square 2.316, df1, p=0.12) and the number of instances of non-recovery terms reduced from 19 to 11.

Where to now

Since completing this project, the local mental health service has undergone staffing changes, including the departure of the recovery champion who conducted this project. There are preliminary plans to revisit the project and to assess how sustainable the changes have been.

Acknowledgements

LHD recovery champion Bryan McMinn and supporting manager Stephen Walker.

WESTERN SYDNEY LHD

Merrylands OPMH: Mental illness self-management through Wellness and Care Plans

Context and project design

This project aimed to improve consumer involvement in their own recovery and care planning. The project initially provided recovery training to Merrylands OPMH staff, with a focus on identifying internal and external consumer resources to enhance the facilitation of consumer participation in individualised care planning.

Level of consumer involvement in project: There were limited opportunities for consumer involvement in this project. However the project team will be looking at how to better include consumers in future recovery-focused projects.

Historically consumers have a very limited role in the development of their care plans. It is hoped that by improving the clinicians understanding of their clinical role in involving consumers (and their carers) in their recovery journey and care planning, positive steps can be made towards the Merrylands OPMH service being more inclusive of the consumer in the care planning and in identifying their own recovery goals.

Identifying internal and external consumer resources to enhance the facilitation of consumer participation in individualised care planning was key to fostering a cultural change in how consumers are involved in their care planning.

This project introduced internal education sessions on recovery to clinicians, consumers and carers. These sessions were based on materials from the OPMH recovery-oriented practice improvement toolkit and targeted approaches such as introducing the wellness plan earlier in the consumers' recovery journey and developing more meaningful personalised care plans for the Merrylands OPMH consumers.

This project was assessed via qualitative feedback from consumers and clinicians on the implementation and use of the recovery-oriented education and consumer wellness plans.

Outcome and findings

The recovery project started with in-services to clinicians to upskill them in relation to principles of recovery-oriented practice and care planning. The project team then conducted an audit of the recovery approaches being implemented and how these related to care planning. The project then moved into establishing a monthly Consumer and Carer Recovery focus group at the Merrylands community health centre. The group started in May 2017, participation in this group is typically between 8 to 12 consumers.

The recovery group program has been highly popular with consumers of the service and has included sessions on flower making, card making, yoga, bingo and a visit by police in regards to elderly safety. These group sessions paired with the staff training in recovery has, according to client file audits resulted in an improvement in consumer participation in individualised care planning.

Where to now

The service is planning for each clinician to facilitate a group session as a part of the staffs' journey into greater engagement with their consumers' recovery journey. The service intends to continue monitoring patient files and compliance regards consumer participation in individualised care planning regularly.

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Summary of findings and discussion

Consumer involvement

The involvement of a consumer consultant on the state-level project steering group was invaluable for the state-level project team and steering group, as well as the LHD project champions who received feedback and advice on how to make projects more consumer-focused. A strong consumer voice was essential to the success of the statewide project and the project team would recommend that any similar projects should include consumer involvement and perspectives.

At the OPMH Recovery Forum, LHD champions and managers presented their projects and findings to their peers. As part of this forum the project's consumer consultant, Ms Sharyn McGee, presented on her experience as a consumer being involved in a state-level project, describing it as scary, challenging, enlightening and positive overall. In explaining her experience Ms McGee noted her initial fear, as someone with a lived experience of mental illness, of participating in a state-level working group primarily consisting of clinical experts. She explained that she sometimes found it challenging to speak up, but with the full support of the project team and steering group she did feel that her involvement was taken seriously and that she was heard when she spoke up at meetings. Importantly Ms McGee did not feel like her involvement was a token engagement. She found it encouraging to see practical outcomes and cultural shifts within the services as a result of her involvement in the project. Both the state project team that she was part of and the LHD champions were very receptive to her ideas on how projects and processes could be improved. Ms McGee expressed how positive the process was for her as a person with a lived experience of mental illness and was encouraged to see her participation as a consumer consultant and the participation of other consumers in the LHD projects as being a positive driver of change.

Consumers were also involved at various levels in some of the LHD projects. This included participation in the design, implementation and review of the LHD projects. LHD teams that engaged consumers as collaborators in their projects reported that their involvement was transformative both in the approach taken but in how the project was perceived by staff and other stakeholders. The findings from this project at both a state and LHD level strongly support consumer and carer involvement in project design, planning, delivery and evaluation; in implementing recovery-oriented practice and fostering a shift in service approach and culture.

Common challenges

There were a number of common challenges that projects, LHD recovery champions and LHD service managers faced in developing, implementing and evaluating their projects.

The impacts of staffing changes, leadership and governance

Throughout the project's lifespan there were several LHD staffing changes that resulted in a change of LHD recovery champion and/or their supporting manager. These staffing changes put several LHD projects at risk and a number of projects lost momentum following these changes. Changes in the LHD champion and or their supporting manager also resulted in staff disengagement in local projects in one case. Engaging new LHD champions and managers into the existing cohort of LHD champions and managers via the project steering group also created some challenges as the transitions were sometimes not seamless as the new participants got up to speed on their LHD projects. In a few cases, a change in the LHD staff resulted in projects being completely redeveloped.

Two Local Health Districts engaged with the statewide project early on and identified LHD recovery champions and supporting managers who participated in the planning workshop.

Unfortunately one of the LHD teams did not get to the planning stage, and the other did develop a project plan but the project did not eventuate despite a great deal of effort from the LHD champion. In both cases, changes in governance and direct line management made it difficult for LHD champions to maintain traction and support for projects. These examples highlight how critical it is to have strong, effective and sustained leadership and support in promoting recovery-oriented practice improvement.

Staff engagement and local governance structures were a challenge faced by Daley et al in their UK OPMH recovery project.ⁱⁱⁱ Dr Daley's insights into these challenges were considered in statewide project design. However, while the project was successful in engaging recovery champions and a diverse range of clinicians (nursing, allied health and medical) and supporting managers, unavoidable staffing movements did impact on some projects.

The challenges faced in relation to staffing movements underline the importance of an effective LHD governance structure to support ongoing change management in key areas of quality improvement such as recovery-oriented practice. This is particularly important for initiatives that will take a number of years to fully implement and bring about a sustained culture of change in local services.

Ethics approval and adding to the published literature

The challenges of obtaining ethics approval for the projects was underestimated by a number of the project teams across the state. These challenges of obtaining ethics approval caused some projects to lose momentum on their practice improvement projects and resulted in fewer teams who will eventually add to the published literature. Ways to address the dual objectives of quality improvement and adding to the evidence base in projects such as this need further consideration.

Evaluating recovery in older people's mental health

Many projects did not use the recommended evaluation measures. In those that did the measures were found useful, noting that a measure or version of a measure specific to older people's mental health would have given more weight to quantifying the outcomes of their projects.

A number of services opted to measure their project outcomes via local processes such as internal file audits and using qualitative feedback. This may be in part due to a lack of OPMH-specific measures, but consideration should also be given to resource and time demands on services in learning and using a new evaluation measure, particularly if it was not viewed as fit for purpose. One of the key issues is that recovery lends itself better to a more qualitative analysis as the model is individual and conceptual. Measuring recovery has its challenges in general, and given that recovery in an OPMH context is a relative gap in the published literature, the application of recovery measures to OPMH has further challenges. Based on the experience from this project, we have identified that evaluation tools specific to or found to be applicable to older people would be a useful development within the published literature.

The challenges of seeding good small-scale ideas

This project was conducted without identified statewide or local-level funding, and relied on leadership, vision and collaboration at the state and local levels to implement relatively small-scale innovative projects. All of the projects undertaken as part of the broad statewide initiative were developed utilising existing resources, with the primary investment from most Local Health Districts being the time of their staff to develop and manage their projects. Some of the projects were more ambitious and required some seed funding, particularly the older peer worker project undertaken by the Central Coast Local Health District OPMH service. The project team sought an external local funding grant to get their project off the ground and have since been successful in seeking additional external funding to keep the program going beyond the initial establishment phase.

The methodology for this project was broadly successful in the short-term given resource constraints. However, ways to support similar small-scale innovative projects and to sustain older peer worker programs in other Local Health Districts requires future consideration. The Mental Health Innovation Fund and peer worker initiatives under the NSW mental health reforms may support this.

The language of recovery

One of the key challenges that the project faced was clearly defining recovery and what it meant within the context of older people's mental health. Given the various definitions and understandings of the term 'recovery', as well as its application to older people's mental health, the National Mental Health Recovery Framework was helpful in allowing the project team to anchor the project's definition and concept of recovery to a national policy document. By delivering a consistent message on the definition of recovery and its meaning within the project context, the project team was able to ensure that LHD projects aligned with the same philosophy. Even so, the project team and LHD recovery champions did find that they were frequently explaining the difference between 'recovery-oriented practices' and being 'recovered or cured' of mental illness.

Creating a new culture is easier than bringing about a culture shift with existing staff

Staff resistance to change is a common and well-documented challenge for health policy and service development and is one of the key challenges recognised within the project design. Effective change management strategies were discussed and used in the establishment phase and throughout the project. A number of projects found it easier to establish new groups, include recovery training in orientation and training for students and new staff, and integrate recovery-oriented practice into new services they were establishing rather than to shift the thinking of existing staff and services. While there was moderate success in improving staffing attitudes towards recovery-oriented practice, these findings underline the importance of integrating key philosophies of care such as recovery-oriented practice into areas like staff orientation.

Timeframes

Initially the statewide project was to be an 18-month project. However, this timeframe extended as the project developed and grew in terms of the challenges LHD champions faced and the time needed to establish meaningful projects that had measurable outcomes. Even at the time of writing the project report, at least one of the projects was still in the establishment phase due to delays in obtaining ethics approval so that the project could add to the published literature. A number of projects decided to forgo sharing their work in peer-reviewed publications in order to implement

their projects and bring about positive practice improvements for staff and older consumers of their local mental health services.

The effectiveness of hosting project materials and project discussion online

One of the unexpected challenges in hosting project materials, videos and an online discussion forum for the project was compatibility/access issues for some LHD champions due to the level of access the various LHD IT systems had to the internet. Issues ranged from some people reporting limitations on downloads, an inability for some to play the videos as it required the installation of flash/software, to limitations on accessing the website and registering for a login to access the hosted content. Hosting the project content behind a login was particularly problematic as there were regular requests for password resets and IT support. This often meant that only some of the LHD champions could access/download some of the resources. These issues resulted in the online discussion forum that was incorporated into the online hub being under-utilised.

The strong engagement between the statewide steering group and the LHD champions assisted in cross-fertilisation across projects, problem-solving and support. Time was allocated in each steering group meeting for LHD champions to teleconference into the meeting and discuss their projects with the steering group (and their peers). This proved to be a very effective mechanism for providing quality expert feedback and advice to the LHD champions as they developed and rolled out their recovery projects.

The access issues with the online resources resulted in ad hoc arrangement to get resources to LHD champions such as the use of email and cloud storage services, before a final workable solution was found (hosting the resources on the HETI website). One lesson learnt is that to find a hosting solution that can be universally accessed by all staff in all Local Health Districts at project initiation is important for a project of this sort.

The good news

The statewide project has been very successful in starting a conversation about recovery and recovery-oriented practice in older people's mental health. The establishment and success of the LHD projects have promoted understanding, discussion, support, reflection and positive experiences around

recovery-oriented practice in older people's mental health services. Despite some common challenges, the statewide project has successfully delivered positive changes in practice and culture in OPMH across most of NSW. Recovery-oriented practice in OPMH has gained some momentum, with initial LHD projects being continued and expanded, and many LHDs learning from each other and replicating projects/strategies developed by their peers. This project has been the start of a journey that will continue through a continued focus on recovery and recovery-oriented practice in statewide OPMH policy directions, models of care, clinical benchmarking and workforce development and as well as local level service improvement.

Lessons learnt and future directions

Reflecting on the project methodology, adopting a 'start where you can' approach worked well. It ensured that those LHDs who had fewer resources to support a project were able to start their recovery journey with a smaller, more achievable projects and as their project developed, they were able to continue that journey in other ways. This approach also allowed for other LHDs to pursue more ambitious projects where they had existing staffing resources and/or structures in place. The project's methodology fostered a culture of participation and challenged pre-conceived notions of 'doing recovery' within the older peoples mental health context through constructive dialogue and participation.

Appointing local champions and a supporting manager was very successful for most projects, but in some cases a personnel change of either the champion or the manager did derail a few projects. Staff turnover was challenging to address in the project methodology and underlines the importance of effective LHD governance structures and strong and sustained leadership to support change management and quality improvement in key areas such as recovery-oriented practice.

Learning from the UK experience, the project sought to recruit a mixture of medical, nursing and allied health staff to support LHD projects. The project team found that buy-in from medical staff was limited, there was high participation from allied health staff, and a large proportion of LHD champions and their managers had a nursing background (as expected, given the staffing profile of older people's mental health services in NSW).

In general, the more successful LHD projects had strong support from local medical staff (eg Central Coast and South Eastern Sydney) and it is recommended that future projects should have strong support from a mix of medical, nursing and allied health personnel at the local level.

The project resources and processes – project literature review, Toolkit, access to UK online training, webinar and workshop – to support the establishment of projects were effective. Whilst there were teething issues in relation to access arrangements for project resources such as the toolkit, these resources seem to have been very useful for the LHD champions. One notable exception was the review and recommendation of recovery evaluation tools, which still presents as an area that needs further consideration for future projects. Promoting and sharing projects through a statewide recovery forum also helped many LHDs consider what their next steps were in relation to continuing their journey in recovery-oriented practice. The use of the statewide steering group meetings to allocate time for LHD champions to dial in and seek advice/feedback on their projects was highly successful. Some LHD champions may have benefited from having this direct access to the steering group earlier in project planning.

In looking at recovery-oriented practice more generally, the project did find similar challenges to other projects across the age spectrum in the published literature around defining and understanding what recovery means. The National Mental Health Recovery Framework was helpful in anchoring the project's definition and the concept of recovery to a national policy document. By delivering a consistent message on the definition of recovery and its meaning within the project context, the project team was able to ensure that LHD projects aligned with the same philosophy.

The involvement of a consumer consultant on the state-level project steering group was invaluable for the state-level project team and steering group, as well as the LHD project champions who received feedback and advice on how to make projects more consumer-focussed. The findings from this project at both a state and LHD level strongly support consumer and carer involvement project design and planning, delivery and evaluation in implementing recovery-oriented practice and fostering a shift in service approach and culture.

The project found that for OPMH services and consumers, recovery-oriented practice is both achievable, and that it also has some specific characteristics that may be different from recovery-oriented practice in adult mental health services.

For older people with mental illness, recovery can be seen as *continuing to be me*, or continuing/regaining an enduring sense of identity, drawing on a lifetime's experience, coping strategies and resilience. This contrasts with younger people, who are often still establishing their identity, coping strategies and resilience as part of their recovery journey. This means a slight rethink about how we approach recovery for older consumers of mental health services, even if some of the fundamental ideas are very similar. For example we learned that peer workers can be successful in promoting recovery-oriented practice in OPMH services, but it was found that those workers needed to be mature and relatable to older consumers and that older peer workers presented as having different training requirements to their younger peers. Importantly, involving older consumers in exploring ideas of recovery and in promoting recovery-oriented practice and implementing practice change at the service level, is highly beneficial and can be transformative for consumers of services, staff and services.

The project found that group recovery/wellness programs are highly valued by older consumers and can promote peer support and social connectedness. Wellness planning was found to be useful as a recovery and self-management process for consumers, particularly following discharge. Future studies could investigate the efficacy of using wellness planning as a relapse prevention strategy for older consumers of mental health services. A focus on collaborative care planning and identifying consumer recovery goals in a collaborative care planning process with consumers of OPMH services can be successful, particularly when supported by engaging, targeted training strategies.

Most projects found that they evolved in small steps incrementally as the project participants underwent their own journey around recovery-oriented practice. Some LHD champions reported that their projects evolved in phases, each involving a new level of understanding of the various facets of recovery that need to be considered under the broader 'recovery' umbrella. One service is now looking at how a consumer's experience of trauma can inform further evolution of their local recovery project.

At a statewide level, recovery-oriented practice within older people's mental health services needs to remain a focus within statewide clinical benchmarking as well as being promoted in models of care and policy documents. Recovery-oriented practice also needs to be a focus within ongoing workforce development strategies. Recovery for older people with mental illness and recovery-oriented practice with these consumers should be a focus area for future research as this is still a relative gap in the published literature.

To support sustainable change, the OPMH Policy Unit and LHD OPMH services will seek to continue the conversation and momentum around recovery-oriented practice through this report and other presentations, publications and strategies in addition to continuing a focus on recovery in clinical benchmarking and policy design.

Endnotes

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