WAAMH

Western Australian Association
for Mental Health

A Sector **Strategic Framework** for the Community Managed Mental Health Sector in Western Australia 2013

Prepared by: Western Australian Association for Mental Health

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Executive summary

The benefits of person-centred, recovery-focused services are well established in literature, research and evidence, but most importantly by the growing voices of people who speak for them. Federal and state governments have stated their intention to fund services based on these approaches.[1] Individuals, their families and key supporters will increasingly have the capacity to vote with their feet as they choose services to meet their needs with the right mix of supports, and level of self-direction. It is critical Community Managed Mental Health ('CMMH') services are well placed to navigate this evolving, person-centred environment. This Sector Strategic Framework (SSF) seeks to guide the sector in this work.

This framework:

- Describes the key principles and processes of mental health support improving outcomes for individuals, their families and key supporters.
- Outlines the Commonwealth and state governments' policy context shaping the direction of community managed mental health services now and into the future.
- Identifies the current investments and investment intentions of governments in developing and expanding CMMHS in Western Australia.
- Introduces a framework by which CMMHS can effectively engage with the change agenda.

This framework is predicated on the principles of recovery and citizenship.[2] Individuals engage in their own unique journey of recovery and require experiences which support this journey when accessing services. In this framework, CMMH services work on two 'bridges' connecting recovery with the important outcomes of citizenship and wellbeing for individuals, their families and key supporters. The first 'bridge' is *Governance and Management* and comprises co-production, family leadership, cultural change, strategic partnerships and systemic advocacy. The second bridge, *Service Delivery* includes personalisation and person-centred practice, self-direction, and community inclusion.

Services engaged in these approaches are inspired and speak enthusiastically about the considerable benefits of putting this work into practice. These include improved outcomes for individuals, their families and key supporters, a more motivated and inspired workforce and a better understanding about how funds can be used more cost effectively and flexibly.[3]

1. See: key reform direction 1 of the Government of Western Australia, Mental Health Commission, *Mental Health 2020: Making it personal and everybody's business*, ('Mental Health 2020 strategic policy') available at: http://www.mentalhealth.wa.gov.au/media_resources/policies.aspx [10 July 2013]; Government of Western Australia, Department of Finance, *Delivering Community Services in Partnership Policy*, available at: http://www.finance.wa.gov.au/cms/content.aspx?id=12662 [10 July 2013]; and Australian Government, National Mental Health Commission, *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, available at: http://www.mentalhealthcommission.gov.au/our-report-card.aspx [10 July 2013].
2. http://www.centreforwelfarereform.org/library/by-date/keys-to-citizenship2.html
3. See for example, Scown, Steve, and Sanderson, Helen, Making it Personal for Everyone: From block contracts towards individual service funds (2011), available at: http://www.dimensions-uk.org/about-us/leaflets-and-resources/making-it-personal-for-everyone/ [10 July 2013].

The SSF will be supported by toolkits,[4] which will provide practical support to agencies to actively engage in conversations with staff, individuals, their families and key supporters to put into practice the changes advocated. A consumer representative on the steering group writes:

> "*This Framework offers guidance on important contextual and cultural drivers that will change the role and characteristics of CMMHS in Western Australia. It offers a sense of shared direction together with additional tools and strategies through which services can work creatively and collaboratively with individuals, their carers and families, service partners and the broader community to build further on its valuable contribution to the mental health sector.*"[5]

This Framework uses terminology consistent with that of the Mental Health Commission, the National Mental Health Commission and National Mental Health Framework.

Individuals refers to people with a lived experience of mental health issues, problems or illness.

Consumer is a term used when describing those who identify as such, and is further used to refer to activities and standpoints that use the term Consumer in order to articulate and promote the common needs of those with lived experience of mental health issues.

Families and key supporters is a phrase used in the framework to describe people who care for or support people with a lived experience of mental illness, in unpaid, informal roles. This includes family members, carers, friends and other key supporters.

Carer is used when describing those who identify as such, and is further used to refer to activities and standpoints that articulate and promote the common needs of those with a lived experience of caring for someone with mental illness as a carer, family member, friend or other key supporter.

Being mentally healthy is important to all Western Australians, as is the opportunity to be contributing citizens and live rich and diverse lives in welcoming communities. These things facilitate and maintain recovery.

4. http://waamh.org.au/development-and-training/projects/sector-strategic-framework-project.aspx

5. Consumer Representative, WAAMH Sector Strategic Framework Steering Committee

1 / Background

1.1 The importance of quality community mental health supports

Being mentally healthy is important to all Western Australians, as is the opportunity to be contributing citizens and live rich and diverse lives in welcoming communities. These things facilitate and maintain recovery. In partnership, we all need to work together for individuals, their families and key supporters to recover and enrich their lives.

While the CMMH sector has a critical role to play, a whole of community effort is required to turn around traditional thinking and shape a better future for individuals, their families and key supporters. Integrated partnerships with the public and private mental health sectors based on mutual trust and respect are fundamental to improving services and supports. Linking and connecting people with health and welfare services; mainstream services such as housing and employment providers; other community based services; and neighbours and peers are also fundamental to support a good quality of life.

The CMMH sector provides supports and services to individuals, their families and key supporters and in doing so makes a valuable contribution to the mental health and wellbeing of West Australians. The Mental Health Coordinating Council reports that:

> "*[c]onsistently, studies show that people living with mental illness who are provided with well-planned, comprehensive support in the community have a better quality of life, develop an improved level of functioning and social contact, and have fewer relapses.*"[6]

The CMMH sector understands community and its importance to health, wellbeing and recovery. It has a particular role to play in mental health promotion, the early identification of individuals, families and key supporters who need support, the delivery of supports and services, treatment and prevention.

- Recovery and community based strategies go hand in hand. Communities are where people are welcomed, accepted, valued, form relationships, and give as well as receive support.
- The sector is ideally placed to address stigma and isolation by reaching out to marginalised people and linking them to people within local services and supports where relationships, based on trust and mutual respect, can be established.
- CMMH services are 'local' and focused on the needs of people in their 'patch'. Diverse and robust relationships and connections can be developed with a wide range of stakeholders close to where people live. These connections facilitate shared care and support and create linkages that reduce the likelihood of gaps in services and supports.
- CMMH services can focus on prevention; anticipate problems posing a risk to someone's hospital admission or readmission to specialist services; and support people who are discharged from hospital or clinics, or exiting prison.

6. Mental Health Coordinating Council, *Social Inclusion: Its importance to mental health* (June 2007), p.2. Available at: http://www.mhcc.org.au/resources/social-inclusion.aspx [10 July 2013].

1.2 What is the Sector Strategic Framework?

The framework outlines some of the fundamental elements underpinning quality mental health services and provides a framework to assist the sector to achieve quality services. This framework advocates for:

- Recovery as the basis for services predicated on hope and optimism and focused on strengths, not deficits; and
- Personalised services that treat people with dignity and respect and recognise the unique circumstances, needs and wellbeing of individuals, their families and key supporters.

Person-centred practice is multi-dimensional and unique to each individual and their family/carer. It requires:

- Informed, committed and sustained leadership, and an active pursuit at all levels of a recovery-focused culture; and
- A genuine commitment to engaging individuals, their families and key supporters by embedding roles for 'experts by experience' throughout the organisation, from governance through to service provision and evaluation, to ensure the delivery of suitable services and supports.

The purpose of the framework is to:

- Provide the current policy context;
- Provide a framework to undertake organisational and service delivery planning; and
- Provide resources to assist in the planning and delivery of services.

1.3 How this framework was developed

The Mental Health Commission (MHC) provided funding to the Western Australian Association for Mental Health (WAAMH) to develop a sector wide strategic plan. It was intended the plan:

- Be developed in partnership with the MHC and include representation from Consumers, Carers and other key stakeholders from the CMMH sector;
- Provide a 'path forward' to prepare the sector for the government's reform agenda and the commensurate forecasted growth; and
- Address issues such as service gaps, service integration, collaboration and quality improvement processes across the sector. It was to be aligned with the Outcomes Framework and other projects funded by the MHC including:

  Interagency partnerships: http://www.waamh.org.au/resources/partnering-ahead-report

  Sector mapping: http://www.waamh.org.au/policy-papers/sector-mapping-report and;

  WAAMH's workforce development activity: http://www.waamh.org.au/training-and-professional-development-programs/waamh-training-home-page

This framework and associated tool kits has been overseen by a steering group with broad representation from the sector and developed in partnership with service providers, individuals, their families and key supporters.[7] To assist this work, consultants were engaged to provide advice and direction to the group. The framework was developed through an iterative process of creative thinking and careful consideration about how best to support change and reform including the key values that need to underpin recovery oriented, person-centred services. Draft tools were developed, reviewed and amended. Draft toolkits were road tested through workshops with stakeholders who gave feedback which led to further refinements.

The steering committee, established to oversee the development of this work, determined a strategic framework would be more appropriate than a plan. A framework enables organisations to shape their own planning processes, as their responsibility as legal entities, by drawing on components of the framework with the best fit for them. The content in the framework document will continue to evolve as the environment and sector changes.

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7. Refer Appendix 1 for composition of the steering group

2 / Current policy context

2.1 The past

Historically the CMMH sector's important role in the lives of individuals, their families and key supporters has not been sufficiently acknowledged or understood. The Mental Health Coordinating Council writes:

> "*Non-government organisations (NGOs) provide services across the full spectrum of mental health care, from early intervention through to rehabilitation and continuing care. They are the human face of the mental health system...Without community support many people with a mental illness enter a descending spiral of readmission, drug abuse, homelessness and prison.*"[8]

Along with insufficient funding, inflexible funding arrangements have been burdensome to the CMMH sector and constrained agencies' ability to provide flexible and innovative services and supports. Block funded contracts requiring output reporting, rather than outcomes and results for people being supported, has been an additional disincentive to the provision of quality services. Whilst it is essential services keep people safe and address the risk of self harm and harm to others, the focus on health and safety has occurred without sufficient attention to demonstrating people are living a good life as a result of services provided. Historically particular communities including Aboriginal people, Culturally and Linguistically Diverse (CALD) groups, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI), and young people have not been sufficiently heard in the design and delivery of services. Families, friends and other supporters, have often been excluded from the planning, delivery and review of services for the people they love.

2.2 State

A number of recent public administration changes, new policy directions and mental health related inquiries are of critical significance to the current and future direction of the CMMH sector. These are summarised below.

- **Economic Audit Committee (EAC) report:** The EAC was established in October 2008 by the Liberal-National Coalition, and was tasked with conducting a wide ranging review of the operational and financial performance of the Western Australian public sector. The EAC Committee's final report, *Putting the Public First*, was released in October 2009. It contained significant recommendations aimed at progressing the role of the public sector as a "*facilitator of services, rather than a direct provider, with all areas of service delivery opened to competition*", with "*citizens in need of services exercising control over the range of services they access and the means by which they are delivered.*"[9] Further information on the EAC report is available at: http://www.dpc.wa.gov.au/Publications/EconomicAuditReport/Documents/eac_final_report.pdf

8. Mental Health Coordinating Council, *Final Report – NGO Development Strategy: Mental Health 2004-2007*, p. 5. Available at: http://www.mhcc.org.au/documents/Projects/FINAL-REPORT-NGO-Development-Strategy1108.pdf [10 July 2013].

9. Government of Western Australia, Department of Premier and Cabinet, *Putting the Public First: Partnering with the Community and Business to Deliver Outcomes*, Economic Audit Committee (2009), p i. Available at: http://www.dpc.wa.gov.au/Publications/EconomicAuditReport/Pages/Default.aspx [10 July 2013].

- **Delivering Community Services in Partnership Policy:** To implement key EAC committee recommendations, in 2011 the Western Australian government introduced a new funding and contracting policy: *Delivering Community Services in Partnership* (DCSP Policy). The DCSP policy laid the groundwork for future commissioning of community services, including mental health. It states, "*[the community services sector] serves the most vulnerable and disadvantaged in our community, and adds immeasurably to the quality of life and social fabric many of us take for granted. These organisations promote active involvement in our society and engage people in a common mission to make our community a better place."*[10]

Further information about the DCSP Policy is available at: http://www.finance.wa.gov.au/cms/content.aspx?id=12662

- Western Australia was among the first in the nation to create a dedicated **Ministerial Portfolio for Mental Health** and was the first jurisdiction to establish a standalone **Mental Health Commission** (both established in 2010).[11] These new initiatives were based on the understanding that the mental health and wellbeing of our community required coordinated, assertive action to be taken across all levels of government. The MHC has responsibility for strategic policy, planning, purchasing and monitoring of services, to promote public awareness of mental wellbeing and address stigma and discrimination, which affects not only individuals, but also their families and key supporters.
- The **Mental Health Advisory Council** (MHAC) was established in May 2011. The purpose of the Mental Health Advisory Council is to "*provide expert, balanced, timely and confidential advice to the Mental Health Commissioner regarding major issues affecting Western Australians with mental health problems, their carers and service providers.*"[12] More information about the structure and functions of the MHAC can be found at: www.mentalhealth.wa.gov.au
- **Mental Health 2020:** The Western Australian Government's vision for mental health was outlined in *Mental Health 2020: Making it personal and everybody's business* as "*[a] Western Australia where everyone works together to encourage and support people who experience mental health problems and/or mental illness to stay in the community, out of hospital and live a meaningful life.*"[13] Mental Health 2020 described how the CMMH sector was tasked with working to re-engage people through practical and psycho social support as well as applying an underlying philosophy, culture and approach placing the individual as the key driver of her/his own recovery journey.

10. Government of Western Australia, Department of Finance, *Delivering Community Services in Partnership Policy*, available at: http://www.finance.wa.gov.au/cms/content.aspx?id=12662 [10 July 2013].
11. Mental Health 2020 strategic policy, p 5. Available at: http://www.mentalhealth.wa.gov.au/media_resources/policies.aspx [10 July 2013].
12. Mental Health Advisory Council, *Annual Report 2011-2012*, available at: http://www.mentalhealth.wa.gov.au/about_mentalhealthcommission/mental_health_advisory_council/council_business.aspx [10 July 2013]
13. Mental Health 2020 strategic policy, p.2. Available at: http://www.mentalhealth.wa.gov.au/media_resources/policies.aspx [10 July 2013].

- **Quality Assurance Framework for WA Mental Health (Gregor Henderson) Report:** A panel of independent experts, chaired by Gregor Henderson, was commissioned by the MHC to inform the development of a quality assurance framework for mental health in WA in 2011. The purpose was to recommend functions and processes that will ensure Western Australians receive the best available evidence based mental health care. This includes consideration of the appropriate roles of the MHC and other entities involved in the delivery and monitoring of services. The report is located at: http://www.mentalhealth.wa.gov.au/mentalhealth_changes/quality_assurance.aspx
- **Revised Mental Health Act:** The green *Mental Health Bill 2012* is informed by the Homan Review (2003), the Henderson report and significant national and international developments. It was developed through extensive community consultation. Revisions to the bill will provide enhanced rights protection for individuals, their families and key supporters. Further information is available at: http://www.mentalhealth.wa.gov.au/mentalhealth_changes/mh_legislation.aspx
- **Establishment of Consumers of Mental Health WA (CoMHWA):** CoMHWA was established in 2011 and is the WA consumers association, run by consumers, that provides systemic advocacy for consumers. CoMHWA's purpose is to coordinate, promote and support the consumer voice within mental health services and the wider community. The establishment of CoMHWA represents a significant milestone in WA for consumers, who have sought for many years to establish a united and empowered voice towards self-direction and empowerment, as achieved through systemic advocacy and collective representation. More information about CoMHWA is available at: http://www.comhwa.org.au/
- The **Review of the Admission and Referral to, and the Discharge and Transfer Practices of Public Mental Health Services in WA (Stokes Review)**. This review has made recommendations to improve the coordination of services and to bring about greater accountability, and promote better management across clinical mental health services, particularly around admission and discharge processes. The report can be located at: http://www.mentalhealth.wa.gov.au/media_resources/policies/stokes.aspx
- **Ten Year Mental Health Services Plan:** In response to the Stokes Review, the government has made a commitment to develop a ten year mental health services plan that will provide a blueprint for future service planning and delivery.
- **Joining the Mental Health Commission and the Drug and Alcohol Office (DAO):** A decision has been made to join the MHC and DAO to better integrate the State's network of mental health and drug and alcohol prevention and treatment services given the substantial link between mental health issues and harmful use of drugs and/or alcohol.

A number of recent changes in Commonwealth policy and priorities are shaping the current and future direction of the CMMH sector.

2.3 Commonwealth

A number of recent changes in Commonwealth policy and priorities are shaping the current and future direction of the CMMH sector. These include:

- **Roadmap for National Mental Health Reform 2012-22.** In 2012 the Federal Government, affirmed its commitment to mental health reform by endorsing the *Roadmap for National Mental Health Reform 2012-22.*
- The **National Mental Health Commission (NMHC)** The National Mental Health Commission was established in 2011/12 and its role is to:
  - Report annually on the effectiveness of mental health policies and where improvements are required;
  - Provide advice on how and where better support can be provided to individuals, their families and key supporters; and
  - Collaborate with others across all sectors to influence positive change

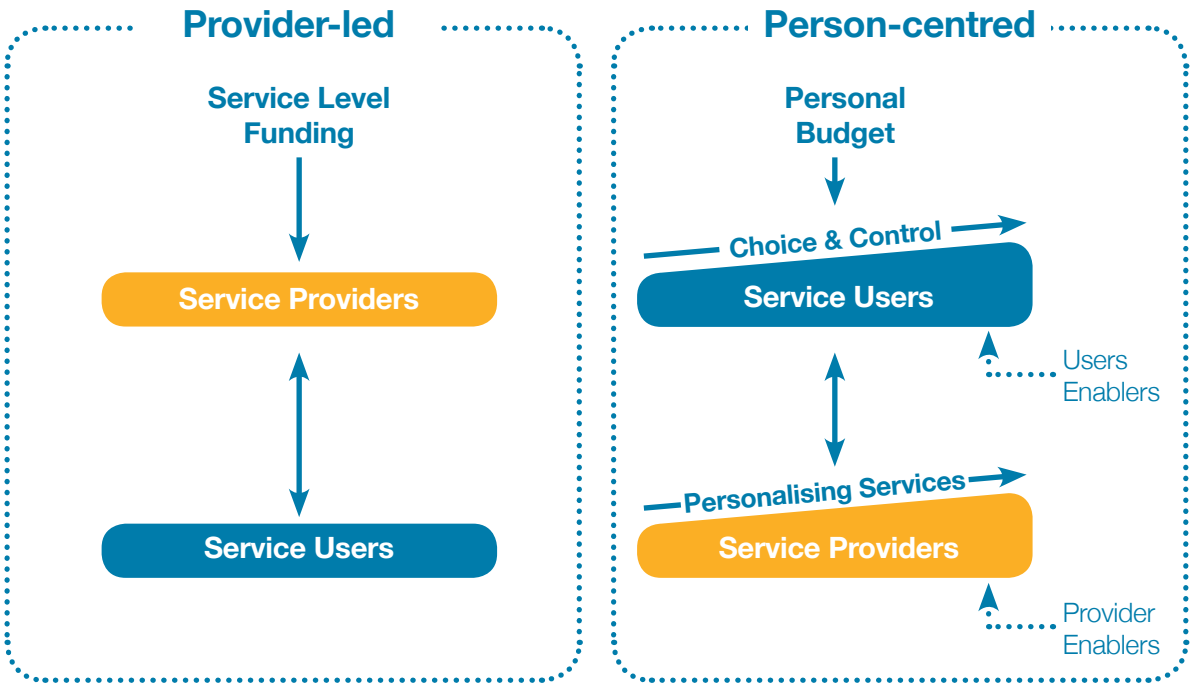
  In 2012 the Commission released the *National Report Card on Mental Health and Suicide Prevention*. Underpinning the federal Governments reform directions is strong support for the principles of Recovery and acknowledgment of the importance of everyone's right to a good life. Further information can be located at: http://www.mentalhealthcommission.gov.au
- **4th National Mental Health Plan: 2009 – 2014.** The plan addresses five priority areas of (a) social inclusion and recovery; (b) prevention and early intervention; (c) service access, coordination and continuity of care; (d) quality improvement and innovation; and (d) accountability – measuring and reporting progress. State Governments report on progress against achieving the plan annually. Further information can be located at: http://www.health.gov.au/internet/publications/publishing.nsf
- **National Recovery Framework:** The Commonwealth Government has a clear vision for the mental health system that reflects and actively puts recovery into practice. The Australian Health Ministers Advisory Council, Safety and Quality Partnerships Sub-committee, oversaw the development of a National Mental Health Recovery Framework, which was released in September 2013 and which flows from a commitment arising from the Fourth National Mental Health Plan. The Government's vision aims to integrate recovery approaches within the mental health sector, promote mental health and wellbeing, and protect the rights of individuals, their families and key supporters. Further information can be located at: http://www.ahmac.gov.au/site/home.aspx
- **National Standards for Mental Health Services 2010:** These Standards have been revised and are applicable across the broad range of mental health services. The new standards include several significant changes. A recovery standard is now included. The 'voice' of people with lived experience, their families and key supporters is also noticeably stronger. *Implementation guidelines for Non-Government Community Services* is located at: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-i-nongov
- **National Mental Health Consumer and Carer Organisations:** The National Mental Health Consumer Organisation, currently under development, will provide coordinated national Consumer vision and direction to national mental health reform in partnership with various mental health Consumers, Consumer organisations and groups across Australia. http://www.mhconsumer.org.au/

3 / Future investment in mental health

3.1 Overview

The procurement of mental health services in Western Australia is changing. As the voices of individuals, their families and key supporters becomes stronger, funders are responding to the demands for more flexibility, increased choice and better quality services. There is wide consensus among individuals, their families, key supporters, communities, services, and funders that recovery-focused and more personalised services provide effective support towards better mental health outcomes. The public sector is moving increasingly toward acting as a facilitator of services, rather than as a direct provider. Funders are moving away from providing 'block funding' to CMMH services; instead, individuals will increasingly be provided funding directly and will choose which services to purchase. The CMMH sector will be expected to support individuals, alongside their families and key supporters, to develop their own person-centred plans which the individual controls and directs. Increasingly, individuals will determine how resources and their own funds are used, have individualised budgets, and be accountable for acquitting those funds.

The graphic below as cited in Williams T, 2011 captures these changes.[14]



14. Churchill Fellowship http://churchilltrust.com.au/site_media/fellows/2011_Williams_Theresa.pdf

3.2 State government investment intentions

The DCSP Policy prescribes greater engagement in planning for joint outcomes, citizen centric services, and requires relevant stakeholders (including service providers, individuals, their families and key supporters) are consulted on the needs and social drivers for the relevant service within the community, as well as the nature and mix of possible services. The DCSP provides the framework by which the MHC will purchase CMMHS and evaluate services into the future.

> "*Through the Commission's role and responsibility for purchasing supports and services, investment will be made to ensure that funded specialist and community services complement and support the important roles of primary care, informal community care and self-care. Individuals, families and carers will have access to more flexible funding and self-directed services.*"[15]

The MHC vision of people *staying in the community, out of hospital and living a meaningful life* is shaping the direction of new services. With an increased focus on prevention and early intervention, resources are being invested to support services closer to where people live and develop sub-acute care. This will require services to demonstrate they can deliver:

- **Recovery-focused services:** Individuals, their families and key supporters, and funding bodies expect services to be recovery-focused and cultures to be hopeful, optimistic and enthusiastic. Resources will be mobilised to contribute to recovery and wellbeing and not comprise activities that maintain the *status quo.* Individuals, their families and key supporters will be actively engaged in planning supports and services that create independence, not dependence.
- **Person-centred services and supports:** Services will need to demonstrate embedded person-centred practice within their culture and show individuals, their families and key supporters benefit from person-centred planning. Their practice should reflects individuals' needs, choices, and aspirations.
- **Capacity to transition to individualised funding.** Services will be increasingly encouraged to convert existing block funding into individually tied funds. The Individualised Community Living Strategy (ICLS) was the MHC's first step in moving towards individualised service delivery. It is the Commission's intention to focus on greater flexibility and innovative service design across all contracted services. The principles of choice personalised planning, self-direction and portability of funding are central to this model and over time it is expected additional opportunities will emerge. The sector will need to adapt its practices to facilitate individualised funding and personal budgets. This will include adapting back office functions so individuals and/or a nominated person among their families and key supports can access their budgets and acquit funds easily.
- **Partnerships:** Services need to demonstrate capacity to work in partnership to achieve outcomes. Joined up services with the individual, their family and key supporters in the centre are essential to recovery. More information about partnerships is provided in section 4.4.4 in this framework.

15. Mental Health 2020 strategic policy, p 13. Available at: http://www.mentalhealth.wa.gov.au/media_resources/policies.aspx [10 July 2013].

The State Government has committed to new investment in community managed services. Examples of these include:

- **Sub-acute facilities:** Sub-acute facilities have been trialed and are being extended in recognition of the importance of individuals having an effective transition from in-patient settings to the community, and the value of having alternative community based options for people who need additional support to maintain their usual way of life.
- **Capacity building in the community sector:** Initiatives to develop the workforce of the CMMH sector through;
  - Training (eg, Certificate 4 in Mental Health and Certificate 4 in Peer Work);
  - Funding leadership development opportunities (eg, Allies in Change); and
  - Providing capacity building grant opportunities to support development and change processes required for the reforms.
- **Court diversion:** A mental health diversion and support program will be piloted and evaluated to determine if it improves criminal justice and mental health outcomes for adults and children who come before the metropolitan magistrates' courts or the Perth Children's Court.
- **Assertive community intervention:** The Mental Health Assertive Community Intervention initiative is metropolitan based and aims to expand mental health assertive community intervention services for children (aged 0-16 years) and their families who are experiencing a mental health crisis, and prevent avoidable emergency department presentations.
- **Early Psychosis Youth Centre (EPYC):** Provision of an Early Psychosis Youth Centre and services which will deliver improved mental health and holistic support for young people aged 15-24 years with early psychosis.
- **Suicide prevention strategy:** The Western Australian Suicide Prevention Strategy is funding suicide prevention through Community Action Plans (CAPs) that are being developed across WA and for at-risk groups. Agency Plans are also being established to build a safety net of suicide prevention strategies within the community. Further information is located at http://www.mcsp.org.au/

The funding package for mental health reform ... provided a substantial increase ($571.3 million investment over 5 years) in funding for more and better coordinated services for individuals who require multiple forms of support, and who are likely to fall through the gaps of service, in order to support better outcomes.

3.3 Federal government investment intentions

The federal government has become an increasingly significant investor in mental health services in recent years. The funding package for mental health reform, announced as part of the 2011/12 budget, provided a substantial increase ($571.3 million investment over 5 years) in funding for more and better coordinated services for individuals who require multiple forms of support, and who are likely to fall through the gaps of service, in order to support better outcomes.

- **Partners in Recovery:** The *Partners in Recovery* program is an important initiative aimed at promoting more coordinated support and flexible funding for people with a severe and persistent mental illness. In 2013, stage one funds were announced and six WA Medicare local regions received funding; four in metropolitan Perth and two regional. http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir
- **Headspace:** Five Headspace services, providing support to vulnerable youth, have been funded in WA. http://www.headspace.org.au/headspace-centres
- **National Disability Insurance Scheme (NDIS, now known as Disability Care Australia):** This scheme will see the introduction of a national rights based entitlement to life time support for people who are eligible. Eligibility will include a proportion of people with psycho-social disability relating to serious mental illness. The scheme will provide the opportunity for people to access individualised funding based on an assessment of their needs. The National Report Card on Mental Health (2012) stated, "*[the] National Disability Insurance Scheme must fully cover the psychosocial disability that results from mental illness*" and "*[all] governments must commit to a National Disability Insurance Scheme that properly assesses and funds support for Australians.*"[16] The Western Australian government has committed to a joint trial of the WA *My Way* model and the Disability Care Australia model across three trial sites over three years. The MHC is working in partnership with DSC to determine how people with a long term psycho-social disability related to mental illness can be included in the *My Way Lower South West Project* in 2012/13. Further information about the NDIS is located at: http://www.ndis.gov.au
- **Personal Helpers and Mentors Program:** During 2013, contracts were awarded to establish additional Personal Helpers and Mentors Programs in WA. This program requires at least one team member is a peer support worker. Further information is located at: http://www.fahcsia.gov.au/our-responsibilities/mental-health/programs-services/personal-helpers-and-mentors

16. Australian Government, National Mental Health Commission, *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, p 8. Available at: http://www.mentalhealthcommission.gov.au/our-report-card.aspx [10 July 2013].

3.4 Investment opportunities for the CMMH sector

The Sector Strategic Framework (SSF) has described some of the Commonwealth and state government emerging and existing investments for the CMMH sector. It is timely for the sector to respond to these opportunities and to become actively involved in shaping a different 'landscape' for the future. The new direction in mental health provides an opportunity for the CMMH sector to:

a. Be increasingly engaged in services that focus on prevention and early intervention, reduce stigma and discrimination, and seek to positively influence community attitudes.

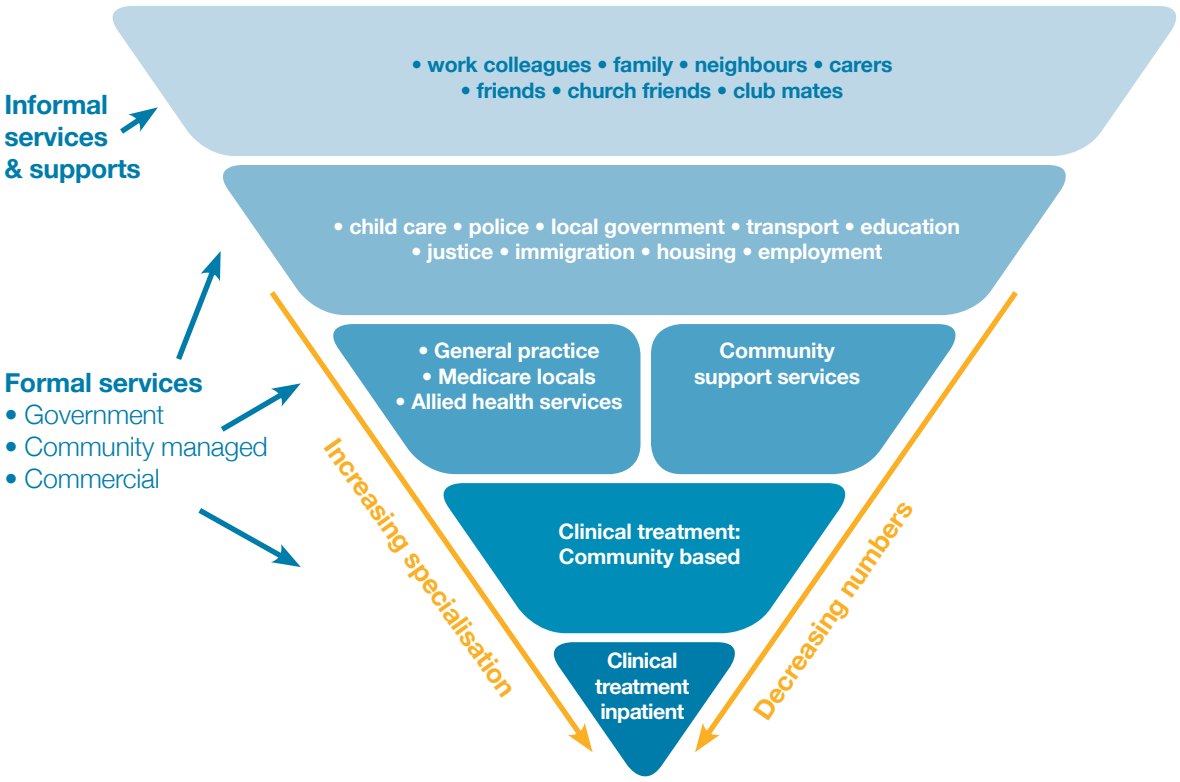
b. Partner more closely with acute and community based public and private mental health services, to ensure service integration, continuity and coordination.

c. Support community providers such as, education, justice, police, alcohol and drug services, housing and employment to better respond to the needs of individuals, their families and key supporters.

d. Consider broadening their scope to include clinical services as part of future service design.

The diagram below describes existing service boundaries.

Types of supports and services



4 / A framework for change

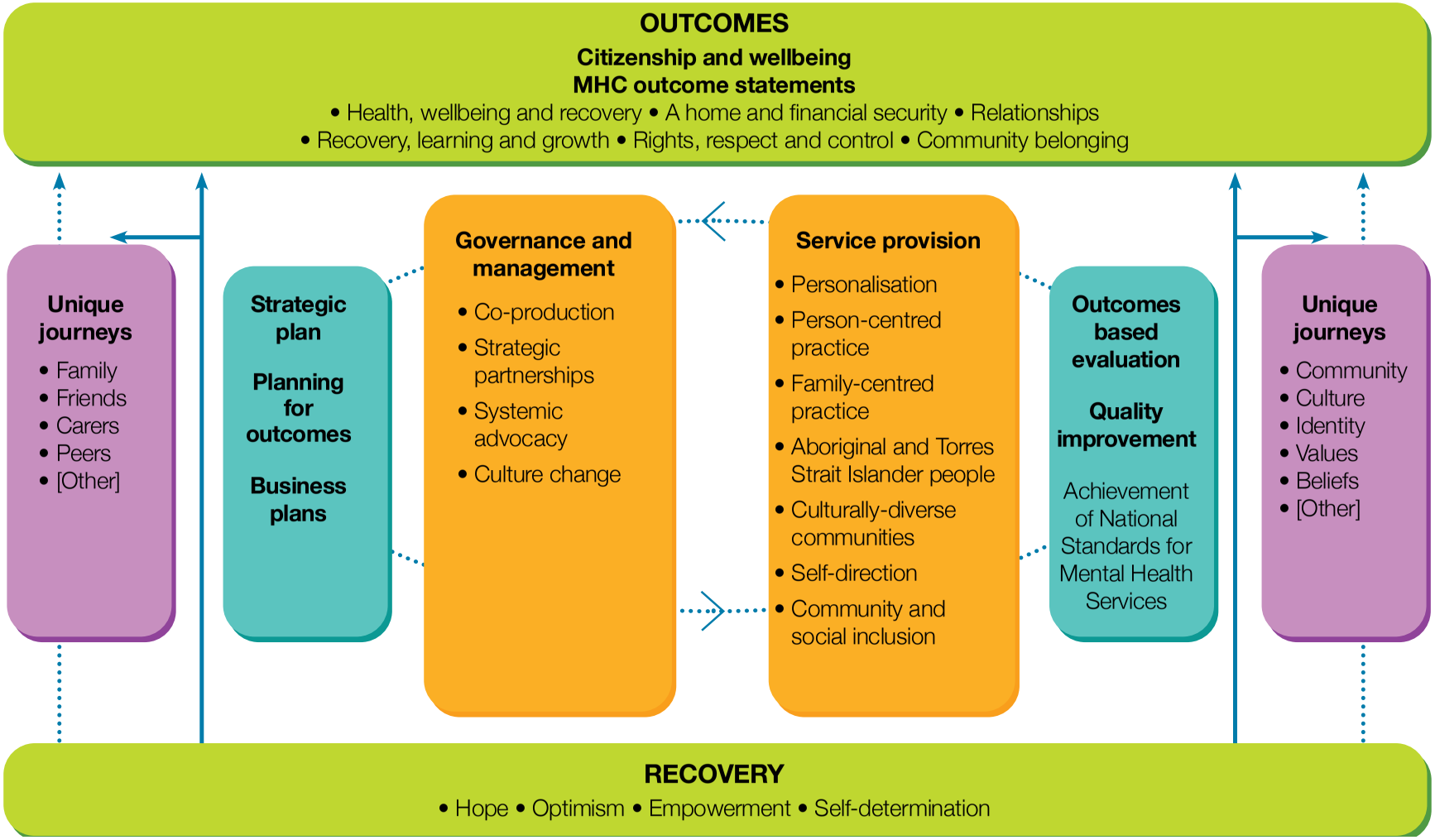
4.1 Overview

The SSF outlines the fundamental elements underpinning quality mental health services and provides a framework for the Western Australian CMMH sector to work together to achieve quality services. The following diagram titled a *Framework for Change* describes the key elements of the SSF:

- **Recovery** as the *basis* of individuals' experience of service delivery.
- Supporting individuals to achieve the **outcomes of full citizenship and well-being** as the *goal* of service delivery.
- The **unique journey** of each individual being the context in which recovery occurs and services are just part of the journey.
- **Governance and management** premised on co-production, strategic partnerships and systemic advocacy and culture change.
- **Service provision** premised on personalisation, person-centred practice, family-centred practice, support for Aboriginal and Torres Strait Islander people, the needs of culturally diverse communities, self-direction and community inclusion.
- **Sound planning and evaluation** informing a cycle of continuous improvement.

The Sector Strategic Framework outlines the fundamental elements underpinning quality mental health services and provides a framework for the Western Australian CMMH sector to work together to achieve quality services.

A framework for change for the CMMH sector



4.2 Recovery

RECOVERY
• Hope • Optimism • Empowerment • Self-determination

RECOVERY

Hope / Optimism/ Empowerment/ Self-determination/ Trauma informed practice

Recovery is a fundamental principle based on the belief that people can and do recover from mental illness. It represents a radical transformation in traditional approaches to services and support. Recovery turns upside down the notion that people are passive recipients of 'treatment' from those in authority with specialised expertise to one which recognises people are natural authorities in what is best for them, and can take control of their own lives. Recovery does not necessarily mean that people become completely symptom free although many people may. It does mean however being able to live meaningful and satisfying lives with improved overall health and wellbeing.

Together with their family, the person seeking to recover will know what determines 'better', what service quality will look like, how it feels to be healthy, and what wellbeing means for them. The following quote describes what recovery can 'look like' from the point of view of a person with lived experience:

> "*I have taken ownership of my illness and I take responsibility for what I do and do not do. I don't let it control me…It's not the whole of my life, it's just a part of my life now...*"[17]

Recovery has also been described by Shepherd as

> "*...an idea whose time has come. At its heart is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life.*"[18]

The Sainsbury Centre for Mental Health summarises the key components of recovery as:

- Finding and maintaining hope
- Re-establishment of a positive identity
- Building a meaningful life
- Taking responsibility and control[19]

Similarly, the National Recovery Framework[20] identifies five practice domains for recovery oriented CMMH services:

- Promoting a culture and language of hope and optimism
- Person first and holistic
- Supporting personal recovery
- Organisational commitment and workforce development
- Action on social inclusion and social determinants of health, mental health and wellbeing

17. Shepherd, Geoff et al, *Policy Paper: Making Recovery a Reality*, Sainsbury Centre for Mental Health, p 1. Available at: http://www.centreformentalhealth.org.uk/pdfs/Making_recovery_a_reality_policy_paper.pdf [10 July 2013].
18. Ibid.
19. Ibid, p.2.
20. National Recovery-Oriented Mental Health Practice Framework , http://www.ahmac.gov.au/site/home.aspx [24 September 2013]

CMMH services with recovery-focused cultures and practices, standing alongside individuals, their families and key supporters to enable them to lead their own recovery journey, will be commissioned by funders and thrive in the future.

Whilst there is no single approach to effective recovery practice, because approaches will be shaped and influenced by the unique needs of individuals, their families and key supporters, this framework outlines some important principles.

Recovery values: Recovery will not be successful without the values of hope and optimism, the genuine belief that change, led by people receiving support is possible. Recovery approaches must be predicated on these values. In the CMMH sector we have seen the negative impact a diagnosis and other labels can have on people. Sometimes they appear to impose a 'life sentence' on people's ability to hope and dream for a better future. Without hopefulness people underestimate their potential, doubt their abilities and are blind to their inherent gifts. As explained by the Social Exclusion Unit, "*there is a consistent danger that professionals will underestimate people's potential. Low expectations can all too easily then become self-fulfilling prophecies*".[21] Creating a recovery-focused culture at all levels of services requires leadership from Consumers, Carers and service providers. Resources to support the development of recovery-focused cultures can be found at: http://www.centreformentalhealth.org.uk/pdfs/Whose_Values.pdf

Strength-based approach: Recovery opens up exciting opportunities for services to develop new approaches. For example, a strength-based approach has been identified as extremely useful in supporting people to recover.[22] A strength-based approach supports recovery through activating people's strengths to better cope with life's challenges, encouraging positive risk taking and self-leadership. Tools such as the *Resilience Doughnut*[23] have been developed adopting the principle that when we explore and understand children's strengths and build on these, significant improvements can be made in supporting people to use their strengths and capabilities to overcome adversity and build resilience in times of stress or crisis. While aimed at children, the Resilience Doughnut provides an informative introduction to the 'lens' of strength-based practice.

Empowerment and self-direction: Empowerment is both a means to, and an aim, in recovery, and refers to the enhanced capability of people to self-determine and self-direct their lives. This requires strategies to enhance hope, choice and decision-making, positive identity development and the existence of genuine opportunities in people's lives.[24] For recovery to happen, empowering change often needs to occur both in terms of personal growth, and within the social environment people live in.[25] For example, individuals and their families who secure housing arrangements and relationships that meet their personal needs often report this as a 'stable ground' of safety and security to launch further progress towards their recovery.

21. *Social exclusion and mental health. Conceptual and methodological review.* C. Morgan, t Burns, R Fitzpatrick, V Pinfold and S Priebe. British Journal of Psychiatry (2007) 191; pp 477-483 cited by the Social Exclusion Unit, p. 479. in Making Recovery a Reality. Shephard, g, Boardman J & Slade M. 2007.

22. See McCormack, John, *Recovery and Strengths Based Practice*, Scottish Recovery Network. Discussion Paper Series. Report No.6 (2007), available at: http://www.scottishrecovery.net/publications-discussion-papers/srn.html

23. The Resilience Doughnut, available at: http://www.theresiliencedoughnut.com.au/ [10 July 2013].

24. [1] A list of these can be found on the Institute of Psychiatry, Kings College London website, available at http://www.researchintorecovery.com/key-publications [17 Aug 2013]

25. Rachel Perkins presentation: *Personalisation and Recovery: the need for a fundamental change in culture and approach* by Rachel Perkins http://www.centrevents.co.uk/pdf/rperkins.pdf [20 August 2013]

Recovery for families and key supporters: Recovery is not just a concept that applies to the person experiencing mental illness. For many families and key supporters, they too seek hope for the future. They want to improve their health and wellbeing and enjoy life to the fullest, but are likely to understand this in the context of their loved one's prospect of recovery. They have a right to a meaning and satisfying life. Recovery is for all those affected by mental illness and the CMMH sector has an obligation to support families and key supporters to recover.

> "*Family and friends also face the challenge of making a recovery in their own right. They too have to re-evaluate their lives, by coming to terms with what has happened and making the necessary adjustments. Relatives, carers and friends must discover new sources of value and meaning for themselves, both in their own right and in their relationship with their loved one. Too often informal carers find their own social networks, contacts and opportunities diminished and find that they too experience stigma and social exclusion.*"[26]

The following sources provide guides for the sector in recovery:

- http://www.centreformentalhealth.org.uk/recovery/publications (this site includes Implementing Recovery, A methodology for organisational change; Making Recovery a Reality and information about Recovery Colleges.
- http://www.centreformentalhealth.org.uk/pdfs/Making_recovery_a_reality_policy_paper.pdf
- http://www.mentalhealthrecovery.com/recovery-resources/documents/100_ways_to_support_recovery1.pdf

Trauma informed care and practice: Individual trauma may be defined as "*an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or threatening and has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.*"[27]

A strong research base is increasingly demonstrating higher rates of trauma in individuals needing mental health supports than the general population. For example, a recent review of homelessness statistics indicates rates between 70-80% of mental illness and 80-90% of significant trauma in homeless populations.[28] It is understood that:

> "*Complex trauma occurs not only in families in relation to children, but in the context of other social institutions. Indigenous people, survivors of clergy and other institutional abuse, asylum seekers and the `Forgotten Australians' are some of the diverse groups who have experienced complex trauma…*"[29]

There is growing recognition such experiences need to be seen within a framework of trauma-informed recovery in order for services to enable individuals, their families and key supporters to recognise and make sense of these experiences in relation to their recovery and support needs.[30] *Adults Surviving Child Abuse (ASCA)*, recently produced *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (2012) ('ASCA Guidelines'). The ASCA Guidelines draw on the current evidence base on trauma to establish a framework and set of standards for trauma informed practice.

26. Shepherd, Geoff et al, *Policy Paper: Making Recovery a Reality*, Sainsbury Centre for Mental Health, p. 5. Available at: http://www.centreformentalhealth.org.uk/pdfs/Making_recovery_a_reality_policy_paper.pdf [20 August 2013]
27. http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx [20 August 2013]
28. See, Australian Centre for Posttraumatic Mental Health. 2012. Literature Review: The Nature of the Relationship between Traumatic Events in People's Lives and Homelessness. Available at: http://www.mindaustralia.org.au/assets/docs/THI%20Literature%20Review%20(200912).pdf [20 August 2013]
29. Adults Surviving Child Abuse, *'The Last Frontier': Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (2012), p. xxx. Available at: http://www.asca.org.au/displaycommon.cfm?an=1&subarticlenbr=366 [10 July 2013].
30. Ibid, p. 25.

The introduction to the ASCA Guidelines states:

> "*…services need to be aware of the possibility of trauma in their diverse client groups (ie as distinct from, and in addition to, trauma-specific services which directly cater to this need). In both cases, services should not only refine their programs to take account of new insights generated by the unfolding research, but should quality assure the results.*"[31]

Under the ASCA Guidelines, key elements of trauma informed care and practice at the service level include:

- **Safety:** Ensure physical and emotional safety.
- **Trustworthiness:** Maximise trustworthiness through task clarity, consistency, and interpersonal boundaries.
- **Choice:** Maximise personal choice, control and self-direction.
- **Collaboration:** Maximise collaboration and sharing of power.
- **Empowerment:** Prioritise empowerment and skill-building.
- **Service policies:** Ensure formal policies are based on the above principles and are consistently implemented and monitored.
- **Screening for trauma:** Ensure a mechanism for screening underlying trauma is implemented in a service/organisational context and fully trauma-informed.[32]

This framework does not elaborate on the principles of trauma informed care as they are comprehensively canvassed in the ASCA Guidelines. It is important for the CMMH sector to keep abreast of and implement trauma informed care and service delivery practices.

OUTCOMES
Citizenship and wellbeing
MHC outcome statements

• Health, wellbeing and recovery • A home and financial security
• Relationships • Recovery, learning and growth
• Rights, respect and control • Community belonging

4.3 Outcomes

OUTCOMES

Citizenship

MHC Outcome Statements

Health, Wellbeing and Recovery / A home and financial security/ Relationships/ Recovery, learning and growth/ Rights, respect and control/ Community belonging

4.3.1 Citizenship

Citizenship is fundamental to the CMMH sector because of the core belief we all have equal rights, opportunities and responsibilities to participate as valued members of society. Despite these rights, the experience of individuals, their families and key supporters with the CMMH sector is these rights are often denied. The Universal Declaration of Human Rights states all citizens are entitled to: "*Inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.*"

31. Ibid, p. xxx.
32. Ibid, p. 12.

Traditionally, the focus of services tended to be on the impact of a person's illness. For families and carers, respite driven by program guidelines rather than family needs, has been the focus. As a community we now recognise that a good life for individuals, their families and key supporters is not possible without full citizenship. This means enabling people to take charge of their lives, and fostering and exemplifying a new paradigm where individuals, their families and key supporters are seen, valued and treated as equal, valuable, contributors to our society. It is incumbent upon the sector to walk alongside individuals, their families and key supporters so they enjoy the benefits of full participation and access to all the benefits communities have to offer.

Professor Simon Duffy describes citizenship as being:

- Respected – "*being able to hold your head up high and getting respect from those around you*"
- Equal – citizens have the same fundamental worth or dignity
- Different – citizens are not identical and have different gifts.[33]

Duffy also describes seven keys to citizenship, which are useful concepts for the CMMHS to draw on in planning and delivering services to promote citizenship. A description of these are located at: http://www.centreforwelfarereform.org/library/by-az/keys-to-citizenship2.html

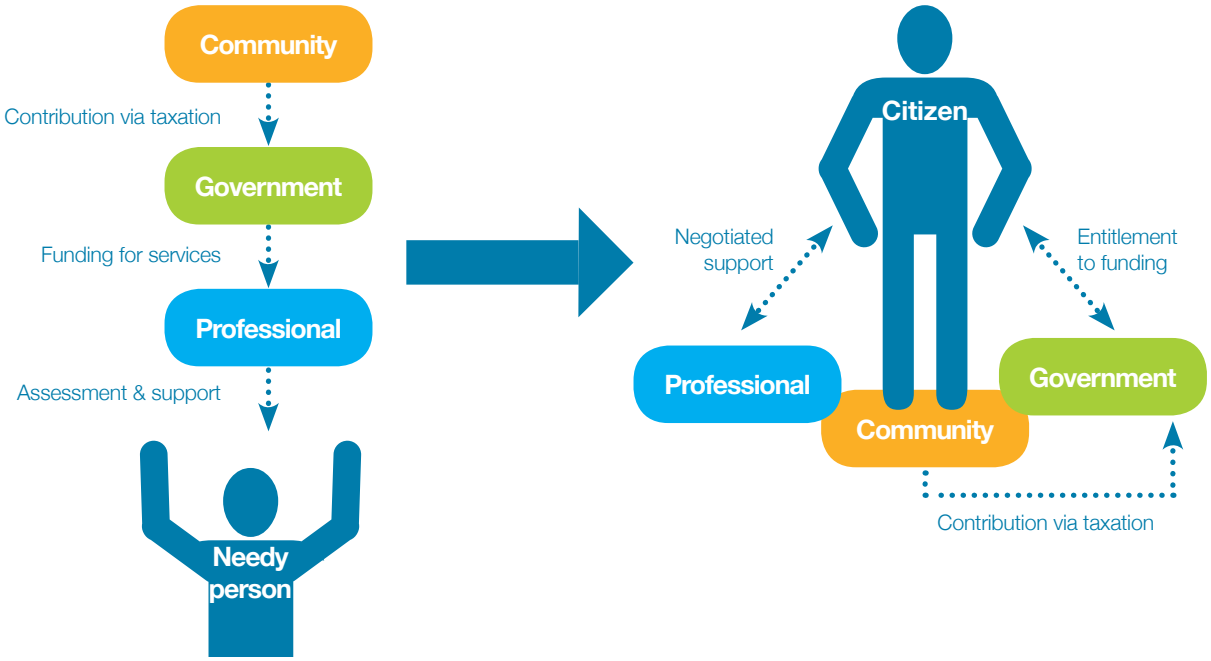
Increasingly, the policies of governments are focusing on the goals of citizenship, reducing the stigma and isolation of individuals, their families and key supporters, and fostering equal rights, opportunities and responsibilities for all citizens. This requires a rigorous approach to understanding the barriers to effective citizenship and the enablers that will help achieve full citizenship, for each individual. These notions call for the CMMH sector to ask questions such as, in relation to housing:

- What does it mean to experience full citizenship in relation to housing rights and status? How does the individual relate their housing situation, and their individual housing goal, in relation to their rights and opportunities?
- What will it take for us to become strong tenancy advocates, what skills do our staff need to address homelessness and to source adequate housing, even if we have not previously done this work?
- What contribution can we make to support someone to get a safe and secure home? What would it take, working in partnership, and acting with resolve, to make the changes required?

Adopting personalisation and embedding this approach in services is a journey rather than a destination. The following website provides more comprehensive information about citizenship and provides tools and resources to build the CMMH sector capacity to apply citizenship approaches to their work: http://www.centreforwelfarereform.org/

33. Centre for Welfare reform, Keys to Citizenship, available at: http://www.centreforwelfarereform.org/library/authors/simon-duffy/keys-to-citizenship2.html [10 July 2013]

Diagram 1: Shift to citizenship model – A new paradigm for the organisation of services



4.3.2 Outcome statements for the CMMH sector

People seek support from the CMMH sector because they have a diverse range of needs and expectations. Outcomes from a citizenship model describe the extent to which those needs and expectations have been met. For example, they can describe changes or achievements that improve health and wellbeing, promote hope and optimism and allow people to enjoy a good quality of life. The CMMH sector's role is to assist people to achieve the outcomes they wish in ways that are most effective for people, their families and key supporters.

Outcomes are important because:

- They focus services on achieving changes in people's lives that they value;
- Communities require transparent information that demonstrates funds are spent appropriately, efficiently and effectively for the benefit of its citizens; and
- Information about results and what contributed to the achievement of those results can inform practice and shared learning, whilst building confidence and hope for a better future.

The MHC, in consultation with people who access services, providers and community stakeholders, have developed a set of outcome statements to identify key results or goal posts of services.[34] Future commissioning of the CMMH sector is now based in part, on the extent to which the CMMH sector can contribute to achieving these outcomes. Outcomes cannot be achieved by the CMMH sector alone. They require the combined efforts of agencies, services and community organisations and citizens working together. The MHC outcomes statements are:

Health, wellbeing and recovery

People enjoy good physical, social, mental, emotional and spiritual health and wellbeing and are optimistic and hopeful about their recovery.

A home and financial security

People have a safe home and a stable and adequate source of income.

Relationships

People have enriching relationships with others who are important to them such as family, friends and peers.

Recovery, learning and growth

People develop life skills, abilities, and learn ways to recover, instilling confidence, self-esteem and resilience for the future.

Rights, respect, choice and control

People are treated with dignity and respect across all aspects of their life and their rights and choices are acknowledged and respected. They have control over their lives and direct their services and supports.

Community belonging

People are welcomed and have the opportunity to participate and contribute to community life.

More information about these outcomes is available at: www.mentalhealth.wa.gov.au/quality

34. The Federal Government is in the process of developing outcome measures for CMMHS funded by the Federal Government. This work was not finalised at the time of printing this framework.

The MHC has an important role to play in ensuring its mental health investments are efficient and effective and make a difference to the overall health and wellbeing of Western Australians. This role includes the influence procurement can bring to bear on investments across government that contribute to better outcomes. As noted in Mental Health 2020, "*[i]n the future smart commissioning for mental health should shift the use of resources to support the development of co-production and innovation, the strengthening of community capacities and attention to the real causes of poor mental health*".[35] Achieving outcomes and their measurement comprises one component within a comprehensive quality framework. Additional information about the quality framework is provided on page 43.

Governance and management

• Co-production • Strategic partnerships
• Systemic advocacy • Culture change

4.4 Governance and management

In this framework we have elected to describe the key components of Governance and Management as:

- **Co-production** – based on the principle people are the natural authorities in their own lives and for recovery to be achieved, people who use services need the opportunity to lead their own services and supports.
- **Strategic partnerships** – building collaborative practice and linkages between individuals, their families and key supporters, health services, mainstream services and communities.
- **Systemic advocacy** – to address stigma, discrimination and barriers to the full participation and engagement of individuals, their families and key supporters.
- **Culture change** – sharing hopeful and optimistic stories of recovery, engaging peer workers and inspirational leadership so recovery values are embedded within all levels of an organisation.

35. Mental Health 2020 strategic policy, p. 44. Available at: http://www.mentalhealth.wa.gov.au/media_resources/policies.aspx [10 July 2013].

4.4.1 Co-production

People, their families and key supporters who have not had the right support to recover are often engaged with numerous services. This can occur by choice, however more often than not people find themselves swept up in a complex web of services and organisations. The more unmet needs a person has, often the more complex the system of support around them. At times people can describe a merry-go round experience as a result of gaps in services and silo approaches that create access barriers due to restrictive criteria, long waits for service, or time limited supports. Engagement with a complex array of services can lead to feelings of being disempowered and overwhelmed, with no one to turn to for help. New service ideas, such as a 'no wrong door' approach focused on integrating services to better meet people's unique needs, have typically emerged as a result of co-thinking and co-design between individuals, their families and key supporters, in equal partnership with service providers.

Co-production is an approach which puts individuals, their families and key supporters at the heart of design and implementation of mental health services and programs. Co-production actively involves individuals, their families and key supporters in the planning, service delivery and evaluation of programs. Co-production involves recognition and value of partner contributions as independent, experienced, and respected voices. They have experience, choices, perspectives and expectations as active decision-makers and collaborative partners.

Co-production provides an opportunity to shift the balance of power towards the person seeking support. A new relationship based on collaboration and sharing can emerge. Duffy provides a useful description of what co-production means linking the value of co-production with the achievement of outcomes for individuals, their families and key supporters.

> "*There is a tendency for us to treat public services as if they exist for their own sake. But this is a false perspective – services exist in order to help achieve outcomes – improvements in health, safety, wealth, contribution etc. Accordingly services must be judged by the degree to which they help us achieve those valued outcomes. Ultimately it is people themselves, often with considerable help, who achieve these outcomes. Once we realise that people are at the heart of achieving valued outcomes then we need to reconsider the relationship between the person and the professional. It is clear that this needs to become a mutually supportive relationship – where the professional supports the person to achieve the valued outcomes – and the person supports the professional to fulfill their responsibilities. This relationship of mutual support and creativity is called the co-production relationship.*"[36]

36. Duffy, Simon, *Personalisation in Mental Health*, Centre for Welfare Reform (2010), p. 37.
Available at: http://www.centreforwelfarereform.org/library/type/pdfs/personalisation-in-mental-health.html [10 July 2013].

Co-production is most powerful when families, key supporters, paid and unpaid services and supports work together with the person using support at the centre. Co-production on the part of services can be flexible and accommodate individual needs as long as the partnership is genuine, based on trust and mutual respect. Co-production can apply at all levels of service and support, and is important to achieve across CMMH services, clinical mental health services, and community based government, non-government and private services. Duffy describes the expertise that the two key players in a co-production partnership can bring to the relationship as citizen expertise and professional expertise:

- **Citizen expertise:** The individual knows their own situation and their own problems in a way which nobody else can; they will know their gifts, strengths, weaknesses, families and key supporters, communities and culture.
- **Professional expertise:** The worker will have seen many people with similar challenges, have experience of what has worked and not worked for others, know where to access information, services and supports and can assist to 'link' people to peers, places and services. Sometimes they can deploy resources to assist in particular areas. [37]

Co-production occurs at two levels:

- **As a principle of how services and systems are designed.** When consumer and carer participation is integral to strategic, and operational planning, service design, and the development of policies and processes, (including financial, HR and infrastructure). Examples include board representatives and Consumer Advisory Groups.
- **In service delivery with individuals, their families and key supporters.** When individuals, their families and key supporters achieve significant voice in the service delivery process, work alongside services, and are seen as central to service-level planning, decision-making and evaluation. At a service program level, this may include a range of participation and contributions, such as focus groups and active volunteering, and at an individual level, involves self-direction in the personalised service they receive. Such practice only occurs effectively when it is supported by the first level, of co-production in governance and management structures, systems and support.

Co-production often presents a cultural challenge for services. Partnering with consumers and carers with experience in co-production design is important for effective cultural change. Effective co-production is further enabled when barriers, boundaries and hierarchies that limit equality, respect, representation, choice and voice are removed. Duffy's view on citizenship and professional expertise can be extended by identifying the additional complementary expertise people with lived experience of recovery, either as individuals or family members, contribute to services.

37. Duffy, Simon, *Personalisation in Mental Health*, Centre for Welfare Reform (2010), p.38.
Available at: http://www.centreforwelfarereform.org/library/type/pdfs/personalisation-in-mental-health.html [10 July 2013].

- **'Customer' expertise:** People bring unique expertise to a specific service, on account of their past or present experience accessing the service. Some people have been involved with a service over a long period of time and will bring historical knowledge of service aspects and how these have affected them. They are the stakeholder most directly affected by service planning and decision-making. They offer important understanding of current service quality, how service changes might affect them, what outcomes are important, and how a service can be designed and ran to best achieve outcomes.
- **Peer worker expertise:** The individual is someone with lived expertise of recovery, who acts as a professional peer, companion and mentor to support someone on their journey. Similarly, families and key supporters have peer expertise in supporting individuals in their recovery, which they can share with others who give support. Where they draw upon the professional expertise they have acquired in this role, they do so in a way that maintains the integrity of peer to peer connection of mutual understanding, empowerment, respect and trust.
- **Representative expertise:** The individual with lived experience as a consumer or carer has an ongoing connection and deep understanding of the group of individuals they are representing. They have authority – whether formal or informal – to represent their common needs interests, concerns and desired directions. They do so across their diversity, enriched by that diversity.

Each type of experience has an important role. Everyone receiving services has customer expertise, in addition to citizen expertise, and hence carry rights and expectations for decision-making in service design and service change. Peer workers provide direct services on a professional peer to peer basis, and often play a key role in bridging and integrating citizen, customer and professional perspectives in service delivery to provide an integrated, recovery culture in which service co-production can thrive. Representatives ensure the broader experiences of individuals, their families and key supporters are used to ensure services, policies and systems support best mental health outcomes, through matching policy and practice to what is most needed and valued by those directly affected.

Individuals, their families and key supporters, in the context of co-production, bring distinct, complementary types of customer, peer support and representative expertise. It is well recognised that carer expertise are derived from the experiences of carers, families and key supporters, and consumer expertise similarly are best provided by individuals with lived experience of recovery.[38]

Practical assistance in co-production can be found at: http://www.tacsi.org.au/co-design/our-approach. Further specific guidance in relation to co-design with family members can be found at:

- United Hospital Fund, *Transitions in Care 2.0*: http://www.uhfnyc.org/publications/880904
- National Mental Health Consumer and Carer Forum, *Supporting and developing the mental health consumer and carer identified workforce – a strategic approach to recovery*: http://www.nmhccf.org.au/documents/MHCA%20CareWF%20Layout%2016-9.pdf
- The Scottish Recovery Network, *Recovery for All, Including Me: Carers and Recovery*: http://www.scottishrecovery.net/Latest-News/recovery-for-all-including-me-carers-and-recovery.html

38. National Mental Health Consumer and Carer Forum. 2004. Consumer and Carer Participation Policy: A Framework for the Mental Health Sector. p.11

4.4.2 Strategic partnerships

The causes of mental illness are complex and often deeply rooted. Underlying factors can be cross generational, cultural, and associated with trauma, poverty, physical ill health and a range of social, emotional and psychological issues. People may experience varying degrees of stigma, discrimination and exclusion from much of mainstream life. These problems cannot be tackled and overcome without an intentional, collaborative whole of community effort. Addressing stigma, discrimination and social inclusion must be a partnership effort. These partnerships involve, and will often be instigated and driven by, the CMMH sector.

Starting closest to the person supported, partnerships must include the vital role families and key supporters play in supporting recovery. It is no longer acceptable to deny families and key supporters their right to be informed and for their needs not to be recognised. They can contribute valuable wisdom and advice to inform solutions and strategies, often based on a lifetime of experience of the needs and wants of the person with a mental illness. In circumstances where someone is unable to make their own wishes known, people's family and key supporters, loved and trusted by the person seeking support, are best able to advocate on their behalf.

Effective partnership between staff, individuals, their families and key supporters, is essential to quality, recovery-focused services that make a difference in people's lives. Staff bring to the partnership resources, funds, knowledge, and skills based on their experience of effective support. Collaboration based on mutual trust and respect where people requiring supports have control over the intent and direction of services, leads to good outcomes.

Alongside the person, their family and key supporters, collaboration and partnership across acute, clinical and community service providers can develop. Clinical staff have an important role to play in working with individuals, their families and key supporters to identify, manage, improve and monitor their mental and physical health needs and outcomes. Clinical interventions frequently play a valuable role in improving overall mental health, in supporting individuals to self-manage and in ensuring safety across the sometimes fluctuating, episodic changes in mental wellness. Recovery critically requires addressing the silos that can emerge for people seeking treatment and supports across clinical and community mental health services. Partnerships ensure all key stakeholders involved in providing mental health treatment and support services share and work collectively towards the goals for recovery identified by the person being supported and their family, and can effectively coordinate both joint supports and transitions between supports. Intra sector and inter sector partnerships across Commonwealth, state and local governments, professional bodies, peak organisations, private and community sector organisations also further facilitate recovery.

The CMMH sector has an important role to play in partnering across communities to build knowledge, understanding and capacity of communities to effectively support individuals, their families and key supporters to become full citizens. The goal of full citizenship includes people feeling they belong, are welcomed, valued and accepted. The CMMH sector is well placed to champion the unique strengths, gifts and attributes of all people, and the valuable contribution they can make to communities. Intentional community development opportunities planned and implemented in partnership with community stakeholders, will increasingly become core business for the CMMH sector.

WAAMH completed a substantial report on partnership in the WA CMMH sector titled *Partnering Ahead* in 2012, a project funded by the MHC. This report describes models and features of successful partnerships, provides examples of these models in action and outlines the learnings and benefits of effective partnership. A partnership resource kit has been created from this report to support organisations pursuing partnership. The report and the resource kit can be found at the WAAMH website: http://www.waamh.org.au/development-and-training/resources/parterneringahead

4.4.3 Systemic advocacy

Community organisations have a critical role to play in leading and engaging in public debate and advocacy on the rights and interests of the communities they serve. In the mental health sector, stigma and discrimination are significant barriers to social inclusion and wellbeing. Overcoming stigma and discrimination requires strong leadership. The CMMH sector, in partnership with other mental health stakeholders, is well placed to lead the journey towards more inclusive communities and reduced stigma and discrimination.

The causes of mental illness are complex and often deeply rooted. Underlying factors can be cross generational, cultural, and associated with trauma, poverty, physical ill health and a range of social, emotional and psychological issues.

The CMMH sector can enhance the wellbeing of the communities they serve by identifying and advocating on systemic sources of disadvantage – which are often described as policies and practices that disproportionately or unfairly impact people on the basis of their personal circumstances. These systemic issues are often observed by workers on the ground – for example:

- policies and practices that have the effect of criminalising mental illness;
- highly burdensome administrative requirements for family members seeking support; and
- in-patient policies and practices that can make it difficult for individuals, their families and key supporters to raise issues of unfair treatment.

CMMH services need to empower and stand beside individuals, their families and key supporters to advocate for their human rights, and to empower them in their self-advocacy efforts. Otherwise, we risk seeing the same problems and deal with only a select handful of detrimental outcomes on a case by case basis. Stemming the sources of disadvantage through education and systemic advocacy is a critical part of achieving equality and fairness for the whole community.

CMMH services are well placed to identify problematic trends on 'the ground', such as a shortage of appropriate supports or services, changing or emerging needs, and individual stories of unfair disadvantage. These stories can be captured and shared with the public and decision makers, forming highly compelling information underpinning a call for change.

Strategies for engaging in highly effective social change work are encompassed in a book titled, *Forces for Good: The Six Practices of High-Impact Nonprofits* by Leslie R. Crutchfield and Heather McLeod Grant. See http://www.forcesforgood.net/

4.4.4 Culture change

Introducing co-production, family leadership and developing strategic partnerships will be new and exciting challenges for many organisations. Many will be familiar with the skills required for effective systemic advocacy. For other organisations this will be new territory. Changing cultures within organisations to embrace the values, principles and practices to make these approaches work will be an important component of *Governance and Management*.

It is beyond the scope of this framework to comprehensively address change management practices here (although we recognise a good understanding of the principles of change management will be required to embrace new service reforms and direction). There are however recurring themes in the literature and experience of CMMH services which have progressed this journey about what it takes to secure change. Some, though not all, of these include:

- **Cultures predicated on the right values and principles.** Recovery-focused, personalised services thrive when they are predicated on the right values. Without hope and optimism underpinning the CMMH sector, recovery efforts will be undermined. Personalisation takes shape when people are treated with respect and dignity and their views, dreams and aspirations are honoured. Co-production works best when people are trusted to join up, at all levels within the organisation, to lend their expertise to reforms.
- **Workforce development.** Our workforce is changing, as is the increased focus on prevention and early intervention, and a better understanding of the needs of young people and those from particular communities. Our workforce will need to respond to the introduction of a quality framework in Western Australia and an increased focus on achieving outcomes. The future will increasingly see individuals, their families and key supporters as customers who will choose services they can direct and control alongside a workforce that has a diverse composition and adequate mix of both professional and lived experience roles. A robust, high caliber CMMH sector workforce is needed to respond to these changes. Comprehensive workforce strategies based on the input, ideas and involvement of individuals, their families, key supporters and staff are needed to change the way we recruit, appoint, develop, train, organise and deploy staff.

People who have gained valuable wisdom and insight (either because of their own recovery journey or as a result of caring for someone recovering) can hold the keys to what it takes to make change.

- **The importance of engaging people with a lived experience of recovery:** People who have gained valuable wisdom and insight (either because of their own recovery journey or as a result of caring for someone recovering) can hold the keys to what it takes to make change. In particular, individual and family participation is critical to supporting the kind of change that puts individuals, their families and key supporters at the centre of designing, planning, delivering, monitoring and evaluating services and supports. Opening up opportunities for people at all levels, to roles such as board membership through to program advisors, training consultants and peer workers, means the valuable experience and skills they bring can be incorporated into practice. Peers can have a substantial influence on system change because they speak with informed authority and from a unique perspective.

  Useful information about the engagement of peers is located at http://www.peerwork.org.au/info-for-organisations

What it 'takes' to make change a reality can appear daunting; Scown and Sanderson write:

> "*What it [change] takes is a combination of energy and commitment; learning and adapting; and using stories about real people to anchor your organisation in reality. It's also about developing a planning process that appreciates the complexity of change; actively involving the organisation's leaders from across all parts of the business; and communicating early, clearly and graphically. Finally, it's about doing it and then reviewing it... Change requires leadership – leadership that engages and energises those involved in the work, ensures decisions are made, makes sure the whole organisation understands and is committed to the journey and most importantly ensures solutions are found to problems and ways found round or through blockages.*" [39]

39. Scown, Steve, and Sanderson, Helen, *Making it Personal for Everyone: From block contracts towards individual service funds* (2011), p. 21. Available at: http://www.dimensions-uk.org/about-us/leaflets-and-resources/making-it-personal-for-everyone/ [10 July 2013].

Service provision

• Personalisation • Person-centred practice
• Family-centred practice
• Aboriginal and Torres Strait Islander people
• Culturally-diverse communities • Self-direction
• Community and social inclusion

4.5 Service provision

The second bridge in our framework, *Service Provision,* is comprised of personalisation self-direction, and community inclusion. Personalisation is discussed under three categories – person-centred practice, family-centred practice, and supporting Aboriginal and Torres Strait Islander people, their families, communities and key supporters.

4.5.1 Personalisation

Personalisation is a philosophy of practice where individuals are valued as the natural authorities of their own lives, and enjoy control of their own choices and decisions. In this way, personalisation puts the principles of full citizenship and recovery into practice. Duffy explains that personalisation:

> "*At its heart is a commitment to demonstrate more faith in the capacities of people and professionals – to give them more trust, flexibility and autonomy...rather than systems or bureaucracy, as the key to bringing about increased well-being and better mental health for all.*"[40]

Although the pathway towards personalisation faces real and perceived barriers, results show personalisation is cost effective and changes people's lives.[41] The National Mental Health Development Unit has considered key components of a whole system framework for personalisation in mental health.[42] These are described on the next page.

40. Duffy, Simon, *Personalisation in Mental Health*, Centre for Welfare Reform (2010), p. 11. Available at: http://www.centreforwelfarereform.org/library/type/pdfs/personalisation-in-mental-health.html [10 July 2010].

41. Social Care Institute for Excellence.2012. Personalisation: A Rough Guide. Social Care Institute for Excellence: London, UK. http://www.scie.org.uk/publications/guides/guide47/files/guide47.pdf

42. See the National Mental Health Development Unit, *Paths to Personalisation in Mental Health: A whole system, whole life framework*, available at http://www.thinklocalactpersonal.org.uk/_library/New_Paths_to_Personalisation_NDTi_April_2013_final.pdf [10 July 2013].

Information and advice, personal motivation and self-help

- I have opportunities for self-help and taking control.
- I have the information and advice I need to feel empowered and make choices.

Creative commissioning

- There is opportunity, choice and innovation in my available support to give me a good quality of life.

Workforce and organisation development

- The people who are paid to provide me with support and treatment have the right skills and approach, and are available when I need them.

Prevention and early intervention

- I get help and advice about how to stay well. Support and help are available to me and my family at an early stage if I begin to feel unwell or things go wrong.

Helpful, person-centred systems and approaches

- The systems I use support me to make my own decisions.
- People listen to me and treat me with respect.

Support for managing personal budgets

- All measures are in place to help me comfortably manage the resources allocated to me, in a way that suits me.

Partnership for inclusion

- My needs are met in a way that is easy for me.
- I get the support I need to participate as a citizen and take advantage of the things available to all.

Good leadership for all

- I can have a leadership role and there is good leadership wherever it is needed.

Fair access and equality

- Opportunities are available to me without discrimination or unfairness.

Support for carers

- I get the support I need to carry out my caring role, stay well and live my own life.

Additional workbooks, resources, and tools to implement personalisation in mental health services are located at www.nmhdu.org.uk

Personalisation is achieved through the implementation of person-centred practice.

4.5.1.1 Person-centred practice

Mental Health 2020 describes person-centred supports and services as one of three key reform directions underpinning services for individuals, their families and key supporters in Western Australia.

Helen Sanderson describes person-centred practice as:

> "*[w]ays of commissioning, providing and organising services rooted in listening to what people want, to help them live in their communities as they choose. Some examples of what you would see where there is person-centred practice:*
>
> - *Person's perspective is listened to and honored*
> - *Individuals have a role in planning the supports they receive & the staff that are hired*
> - *Regularly checking with the individual and their family to see what is working and not working in their lives*
> - *Employees know their roles and responsibilities in supporting people*
> - *Staff are matched with people based on skill and common interests.*"[43]

Person-centred practice describes the approach which supports personalisation for people. A wide range of resources are now available to assist the CMMH sector develop, promote and grow person-centred practice. Sanderson has developed a practical guide called *Habits for highly effective staff – using person-centred thinking in day-to-day work.* This resource is located at: http://www.helensandersonassociates.co.uk/reading-room/how/person-centred-thinking/habits-for-highly-effective-staff.aspx

4.5.1.2 Family-centred practice

Families and key supporters are central to the recovery, health and wellbeing of those they support. This is because recovery occurs best where strong, positive relationships exist between the people with whom individuals have long-lasting, significant and positive connections with in the community. Families and key supporters can bring valuable additional insights into the support needs, strengths and unique identity of the person they support; and often provide the primary source of support and response for individuals at times of crisis and setbacks. Families and key supporters have dual needs, firstly in terms of being equipped to provide effective, recovery-focused support to the person they care for.[44] Secondly, families and key supporters seek to recover and rebuild their own lives from the challenges, pressures and hardships often faced in the course of supporting the person cared for.[45]

43. Helen Sanderson Associates, *Person Centered Practice*, available at: http://www.helensandersonassociates.co.uk/what-we-do/how/person-centred-practice.aspx [10 July 2013].

44. See for example, the University of Kansas, School of Social Welfare, Office of Mental Health Research and Training, Toolkit, available at http://mentalhealth.socwel.ku.edu/projects/EBP/pyschoeducation.shtml [10 July 2013]

45. See for example, Wesley Mission, *The Wesley Report – Keeping Minds Well: Caring till it hurts* (2012), available at: http://www.wesleymission.org.au/Research/Mental_Health/ [10 July 2013].

Family-centred practice is necessary to respond to the alarming gap between the needs of family members and the extent of service provision that routinely respects, integrates and addresses the important role families and key supporters have in individual's recovery outcomes. The Gatter Sector Mapping report *A Project to Map the Community Mental Health Sector in Western Australia* found that the most marginalised people were not being supported by CMMH services. Whilst some individuals are alone and isolated, the primary support for many people who do not access services is their family. Legatt writes:

> "*it is not morally defensible to continue to allow families to carry the burden of care without giving them the information, training and support necessary to bring about better outcomes for the patient, as well as better outcomes for the carers themselves.*"[46]

Some of the reasons for developing expertise in a family-centred recovery approach include:

- Studies have demonstrated that almost one third of clients of mental health services are parents.[47] There is a growing evidence base identifying the importance of attachment and the impact of poverty and trauma on children's mental health. Similarly, evidence is emerging about the importance of supported parenting, giving and receiving love, and empowerment, as a potent force for recovery.[48]
- International experiences show recovery rates from serious mental illness are highest when the family is actively engaged and supported. For example the *Open Dialogue Project* in Finland demonstrates the benefits in engaging with families to improve the likelihood of recovery.[49]
- Family members often serve as the only support system for people, fulfilling essential roles such as assisting in the initial stages of service engagement, in the process of identifying strengths and goals, and in supporting the recovery process.
- Family members often experience lower quality of life related to high levels of care giving. The Wesley Report identified "*looking after a relative with mental health issues exposes the caregiver to a range of risks and deterioration in quality of life*".[50] Almost 90 per cent of respondents to the report who were carers reported a negative impact on their physical and mental health.[51] This points to an urgent need by families and key supporters for more sustainable levels of care in order to restore life balance and enhance wellbeing.

46. Dr. Margaret Leggatt in her chapter *Meeting the Challenges in Families as Partners in Mental Health Care,* 2007, quoted in Private Mental Health Consumer Carer Network (Australia), Carers Identified? Identifying the Carer Report 2010, p.2. Available at: http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/FFCAA63D82FC2D90CA257A5C007C996A/$File/carers.pdf [10 July 2013].
47. Howe, Deb et al, 'Estimating Consumer Parenthood within Mental Health Services: A Census Approach', *Australian e-Journal for the Advancement of Mental Health*, (2009), 8(3), p.231. Also. Maybery, Darryl et al found that 20.4 per cent of people receiving mental health service support have dependent children. See'Prevalence of parental mental illness in Australian families', Psychiatric Bulletin, (2009), 33(1), p. 23.
48. See MDA Online, Medical Journal of Australia, *Parental mental illness is a family matter*, available at https://www.mja.com.au/open/2012/1/1 [10 July 2013]; COPMI, Gateway to Evidence that Matters, Putting Families at the Centre of Recovery, Edition 14 – March 2013, available at http://www.copmi.net.au/images/pdf/Research/gems-edition-14-march-2013.pdf [10 July 2013].
49. See, for example: http://www.youtube.com/watch?v=ywtPedxhC3U ; Seikkula, Jaakko et al, 'Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies', *Psychotherapy Research*, (2006), 16(2), pp.214-228.
50. Wesley Mission, *The Wesley Report – Keeping Minds Well: Caring till it hurts* (2012), p.6. Available at: http://www.wesleymission.org.au/Research/Mental_Health/ [10 July 2013].
51. Ibid.

Services that meet the needs of family members are proactive in engaging and identifying how to best support individual family members, as well as the individual supported, in the context of the person's individual recovery and positive, whole-of-family outcomes. Family-centred services require a commitment to provision of adequate time, resources and supports for family members to be well informed and to experience quality support, met needs, and positive relationships with those providing formal, paid care.[52]

4.5.1.3 Supporting Aboriginal & Torres Strait Islander people, their families and communities

The impact of mental illness on Aboriginal and Torres Strait Islander people and communities has been significant. The historical and enduring impact of discrimination and prejudice has contributed to trauma and resultant mental illness.

It is a testament to the resilience of Aboriginal and Torres Strait Islander people therefore, that Aboriginal elders and leaders within the community are now contributing to an increased understanding of how best to address the needs of their communities.

One example of this work is the Aboriginal mental health project *Looking Forward*. The project is a partnership initiative using a participatory action research process. The project via community consultations, have identified some important components of good mental health practice with Aboriginal people, their families and communities such as:

- The need for recognition and understanding of Aboriginal people and their culture.
- Addressing loss, grief and trauma associated with past injustices and suicides in the community.
- Collaborative (equal power) partnerships between Aboriginal and non-Aboriginal people.
- There is a need for Aboriginal healing centres, one use being a place where people can go in times of crisis.
- Having access to Aboriginal workers in health services.
- Building trusting and mutually accountable relationships between service providers and Aboriginal families and communities (not just with individuals).
- Understanding the Aboriginal concept of 'shame' may in part contribute to Aboriginal people's reluctance to seek help.[53]

WAAMH looks forward to the completion of this work and the contribution it will make to the CMMH sector on how to play a more informed and authentic role in supporting Aboriginal people, and promoting the wellbeing of their families and communities in Western Australia.

52. The Rethink website, whilst UK based, has useful resources for family members and professionals. See Rethink Mental Illness, *Confidentiality & Information sharing for carers, friends and family,* available at: http://www.rethink.org/carers-family-friends/what-you-need-to-know/confidentiality-with-family-friends [10 July 2010].

53. Ruah Mental Health, *Looking Forward Project*, available at: http://www.ruahmentalhealth.com.au/page/looking_forward_project [10 July 2013].

4.5.1.4 Culturally diverse communities

Western Australia is a diverse and multicultural community. People from a range of cultures who come to Western Australia make a rich and significant contribution to our lives. As Australians we support the economic, social, and humanitarian benefits of migration and settlement of people from diverse communities.

Despite these contributions, the circumstances surrounding migration and settlement can leave people vulnerable, traumatised and isolated, particularly for refugees, asylum seekers and humanitarian entrants. When people from different cultural backgrounds become unwell, particularly as a result of mental illness, their experience of receiving adequate support, treatment and services has for some, been wanting. The reasons for this are complex. People from culturally diverse backgrounds are less likely to access mental health support for a range of reasons. Those on low incomes, who don't speak English, here without family and friends, and victims of torture or trauma, are particularly vulnerable. Barriers that impede access to services include external factors such as discrimination and language barriers and internal factors such as issues associated with grief and loss, sometimes compounded by having to leave loved ones behind and associated feelings of guilt and remorse.

The CMMH sector can make a valuable contribution in supporting all people to be valued citizens. In order to provide quality person-centred services we needs to respond to the diverse needs of people from all backgrounds. Specialist multicultural mental health services and supports are to be congratulated for the valuable services they provide. In addition to this the principles of person-centred practice demand everyone's individual needs, including their cultural, linguistic and religious needs, become an integrated part of service design and planning by all mental health services. Partnerships with specialist agencies are important in a context of a shared ownership and commitment to culturally responsive and competent supports, directed by the person and their family seeking support.

The National Cultural Competency Tool ('NCCT') for mental health services is a resource pack designed to assist mental health service providers work across cultures and improve service quality and delivery to people from diverse backgrounds. It was developed by Multicultural Mental health Australia (MMHA) in partnership with the MHC and is aligned with Standard 4: Diversity Responsiveness of the NMHS.

The following websites provide a link to the competency tool and additional useful information for supporting people from culturally diverse communities. http://www.health.gov.au/intenet/main/publishing.nsf/content/mental-multi-fact

4.5.2 Self-direction

If we recognise everyone is unique with their own gifts, strengths, attributes, and are the natural authorities in their own lives, then it makes sense people can and should direct their own services and supports. A self-directed approach is integral to personalisation.

> "*Self-directed support is a system of providing support to individuals and families who need extra support while enabling them as much control over that support as possible. It involves a radical change in the role of the lead professional or care manager who now focuses on ensuring that people take as much control as makes sense to them – through planning, implementation and review – but without forcing people to take on responsibilities which would be inappropriate.*"[54]

54. Duffy, Simon, *Personalisation in Mental Health*, Centre for Welfare Reform (2010), p. 12.
Available at: http://www.centreforwelfarereform.org/library/type/pdfs/personalisation-in-mental-health.html [10 July 2013].

The discussion paper *My Life: My Way* describes self-directed services as "*...people being at the centre of determining what they need and how services work for them. It re-casts individuals, their families and key supporters service users from passive…clients into active directors of their support arrangements.*"[55] The paper describes the following principles for self-direction:

- People are best placed to identify the supports and services they need. The skills and capabilities of individuals, families, key supporters and communities are a rich resource that should be built into support arrangements and the design and implementation of services;
- Service systems should seek to support each person's holistic life needs and aspirations rather than addressing symptoms;
- People and communities are entitled to make decisions for themselves.
- There is no one size that fits all.[56]

4.5.2.1 Self-directed budgets

Readers familiar with the literature about self-direction will appreciate the view that it should include control over resources, particularly individualised budgets. Some stakeholders in mental health adopt the view that self-direction is not possible without people having the ability to control and direct their own funds.

Where self-direction includes the capacity for tied or individualised funds, the Presidents Freedom Commission identified that self-direction:

> "*improves consumer satisfaction with services compared to traditional community mental health services…due to the focus on recovery rather than symptoms; the flexibility of the approach in meeting individual needs; and the support provided by counsellors and peers in articulating goals and developing spending plans.*"[57]

It is acknowledged having access to, and the capacity to self-manage, an individual budget can be a powerful tool to aid recovery. However, we believe it is important to differentiate between individualised funds and individualised support. Budgets and the spending plans on which they are based are developed from comprehensive person-centred planning, and it is the process by which these plans are developed which drive the quality, intention and integrity of the planning process. Funds allow people to purchase what is important to them and are one tool within an overall recovery approach.

> "*Individual packages of support have enabled better tailoring of support to meet people needs. The involvement of individuals or their carers in designing these packages of care is instrumental to ensuring that service solutions are responsive. The package is based on what the individual wants and needs rather than what an agency allocates to eligible residents.*"[58]

55. Government of Western Australia, Department of Finance, *My Life: My Way*, p. 3. Available at: http://www.partnershipforum.dpc.wa.gov.au/CurrentProjects/Documents/2087_MY_LIFE_MY_WAY_discussion_paper.pdf [10 July 2013].
56. Ibid.
57. Office of Disability, Aging and Long-Term Care Policy. 2007. *The Contribution of Self-Direction to Improving the Quality of Mental Health Systems*. Office of Disability, Aging and Long-Term Care Policy: US Department of Health and Human Services, p.4. http://www.aspe.hhs.gov/daltcp/reports/2007/MHslfdir.pdf [20 August 2013]
58. Parker, Simon and Bartlett, Jamie, *Towards Agile Government*, State Government of Victoria, State Services Authority (2008), p. 6. Available at http://www.egov.vic.gov.au/victorian-government-resources/trends-and-issues-victoria/citizen-centric-service-victoria/towards-agile-government-in-pdf-format-format-506kb.html [20 August 2013]

4.5.2.2 Community and social inclusion

Supporting people to be connected and involved in their communities is a core role of the CMMH sector. This is because the determinants of mental illness are inextricably linked with social and emotional isolation. Studies have confirmed the links between social inclusion and rates of recovery from mental illness.[59] For example, Pervalin and Goldberg, in a large scale UK study of over 15,000 people, demonstrated how low social support increased chances of onset and decreased chances of recovery.

Social exclusion is the experience of many individuals, their families and key supporters. Historically people have tended to be supported in small communities through extended supports and kinship. In post-industrial times many of the rich and valuable connections and relationships these arrangements provided have been replaced by formal, professionalised services. Fortunately the value and importance of families and communities to inclusion are re-emerging. It is now recognised that large service systems cannot replace friends, families, peers, neighbours, work colleagues and sporting buddies. For individuals, their families and key supporters, the emotional, social and health benefits of feeling a sense of belonging, inclusion and being valued are now well established.

> "*Mental illness is closely associated with social exclusion due to a number of factors, mainly socially derived, that have been attached to it, including fear, misunderstanding, stigma, discrimination and an entrenched belief that the appropriate medical and social response is separation from society.*"[60]

Social exclusion is social isolation arising from a complex of stigma, discrimination and/or chronic disadvantage. It often comprises a combination of linked problems such as unemployment, physical ill-health and chronic disease, inadequate housing and low income. For some, this may increase vulnerability to substance use addiction, offending or becoming a victim of crime, or to complex family challenges and circumstances that require additional support.

The work of the CMMH sector means supporting people to secure those fundamental things communities can provide that many of us take for granted. This includes access to health providers, housing, employment opportunities, specialised services, and so on. People in recovery, particularly in the early stages, may need support from GPs, psychiatrists and community mental health services and at times, acute hospital settings. People need safe and secure housing to remain healthy and well. A lack of secure housing can:

> "*... form part of the picture of a weakened social network, family breakdown and lack of community participation. Living alone, in poverty, or being homeless, have all been shown to have a negative impact on mental health.*"[61]

Similarly employment is strongly associated with positive mental health. Making a contribution, giving as well as receiving and having a sense of value and worth for contributing, preferably through paid employment is universally accepted as mainstay contributors to wellbeing.

59. See, for example, Pevalin, David J and Goldberg, David P, 'Social precursors to onset and recovery from episodes of common mental illness', *Psychological Medicine*, (2003), 33(2), pp.299-306.
60. Mental Health Coordinating Council, *Social Inclusion: Its importance to mental health* (June 2007), p.5. Available at: http://www.mhcc.org.au/resources/social-inclusion.aspx [10 July 2013].
61. Mental Health Coordinating Council, *Social Inclusion: Its importance to mental health* (June 2007), p. 21. Available at: http://www.mhcc.org.au/resources/social-inclusion.aspx [10 July 2013].

One of the most significant challenges for the CMMH sector is promoting the workplace cultures which understand multiple factors contributing to social exclusion and its impact on mental health, and undertake individual and systemic efforts to increase social inclusion.

For a number of reasons, individuals can face significant barriers to forming relationships and building connections once they have become isolated from others. The role of CMMH sector is to be intentional in facilitating and building informal community connections and supports, overcoming those barriers and to be mindful of not unwittingly undermining connections that already exist.

The CMMH sector can work in holistic ways with individuals to identify their needs based on informed awareness of common risk factors and barriers to their overall wellbeing, such as identifying housing, financial, safety, physical and dental health needs. This may include a working understanding of medication risks and side-effects that impact on day to day living, participation and overall health. This often requires provision of intensive planning and support towards individual goals across a range of life areas.

Advocacy is required at an individual, local and systemic level to increase social inclusion. At an individual level, advocacy can support individuals to access services, ensure their needs are met and enhance opportunities in life areas. At a local level, partnership approaches can catalyse coordinated, innovative and successful approaches to facilitating access and opportunities that promote recovery. At a systemic level, advocacy efforts promote the design and delivery of systems premised on the equal rights of citizens to social inclusion and good quality of life.

The goal of services is to:

- Enhance opportunities available for individuals to strive towards their full social, cultural and economic citizenship.
- Overcome barriers to access appropriate supports and services.
- Intentionally build the confidence, skills and capacities of people supported with the aim of making the paid service redundant, ensuring the person has their own rich and robust network of informal unpaid supports, and;
- Promote positive attitudes towards people regardless of their mental health status. Stigma and discrimination begin to be addressed when communities understand and connect mental health with recovery and citizenship.

The diagram[62] on the following page describes some of the key components to social inclusion.

62. Ibid, p.19.

Choice
Exercise, sport & other self care
GP and complementary health care
Hospital
Specialist mental health clinical services
Other services / supports
Financial counselling and advice
Income support & emergency relief
Housing & accommodation support services
Religious and spiritual participation
Work and satisfying employment
Study, learning hobbies, interests
Family, friends and carers
Leisure, clubs & social contacts
Participation in social movements and events
CLOSE RELATIONSHIPS
Person in Community
Enabling public policy
Determinants of health

Numerous practical workbooks and guides are available to the CMMS to support best practice in delivering community inclusive services to individuals, their families and key supporters.

Additional information is located at:

- Ideas WA: Information on Disability Employment and Support Western Australia: http://www.ideaswa.net/admin/social-participation-manual.html
- Mental Health Coordinating Council, *Social Inclusion: Its importance to mental health* (June 2007), available at: http://www.mhcc.org.au/resources/social-inclusion.aspx
- *Weaving Tapestries: A Handbook For Building Communities* by Tim Muirhead (widely available for purchase).

Outcomes based evaluation
Quality improvement

Achievement of National Standards for Mental Health Services

4.6 Quality improvement informed by lived experience

We have established that individual, their families and key supporters are seeking more flexible services over which they have more control. Increasingly people will choose services of high quality that respond to their individual needs. One family member describes quality for her and her family as follows.[63]

"What does quality mean to me? It means 'fit for purpose'. And the question is – whose purpose? If we are to experience services that are fit for the purpose of people who use mental health services – i.e., people with lived experiences of mental health challenges, their families, friends and other supporters, then we need to start by asking them to identify what they want a service to deliver, at a systemic and organisational level.

And for families, that means services that are open in the middle of the night, on holidays, services that work with us, services that value relationships, services who understand that we've been through an enormous amount of trauma and that just picking up the phone is a Herculean task, who ring when they say they will, turn up when they say they will, services that can provide electricians, lawn mowing services, skilled financial triage advisors, cleaners, baby-sitters, services that ask "how are you going?", "what can I do to support you?", "do you need a hand with anything?"

And once our requirements of a service are established, quality processes demand that they are designed, pre-tested, implemented, evaluated and monitored by the people that identified these requirements in the first place. That way, outcomes are far likelier to be what we want them to be – recovery for all. That is quality."

63. Carer Representative, WAAMH Sector Strategic Framework Steering Committee.

Another person describes quality for her as follows[64]:

> *"Quality is in every moment and every staff member. It is felt and tested by the person accessing the service and interaction with the service, and shapes what happens to future interactions. It is our experience of how well a service reflects what we want to experience: 'Am I listened to? Respected? Supported in a way that feels right for me? In this interaction, are my rights intact, my needs heard, my expectations met, are the things I hope to achieve nurtured to grow? Is hope nurtured? Do I leave feeling enough safety and trust has been built to connect in the next moment?' Poor quality leaves us feeling worse than when we started, good quality leaves us feeling we are better off for trying out a service. For many consumers who have been left worse off by poor quality, having good quality for the first time, and every time to come, is vitally important to us."*

Department of Health South Australia note that:

> *"Safety and quality in mental health care depends on a commitment to consistently achieve the highest possible standards of care in all health care settings, adhere to current evidence-based practice and increase the likelihood of desired outcomes for consumers….. The focus of all safety and quality strategies is to enhance consumer health and wellbeing."*[65]

Safety is also critical in mental health service delivery, with services needing to take action to identify and reduce risks that may arise from mental health service delivery.[66] Examples of safety initiatives include robust operational policies, a safe and skilled workforce, incident prevention and reporting, and compliance with standards.[67] Recovery-focused, person-centred and trauma-informed practices have been described throughout this report as important to the experience of safe, high quality supports by individuals, their families and key supporters.

Quality service cultures pursue an integrated approach to quality, in which quality roles and responsibilities are incorporated into general workforce roles and understood as components of a shared quality system, and in which a strong ethos of continuous quality improvement is led across component programs, teams and levels of service. They may pursue external quality accreditation or other quality strategies with focus and drive quality improvement. More than gather data, they have the information management skills to effectively act on information.[68] Governance of quality is essential to oversee the effective performance of planning, monitoring and evaluation systems, policies and indicators.[69] A robust quality management system exists to enable services to continually improve the services they provide in order to achieve the best outcomes for people. It is therefore essential that quality is understood and developed in a way which strongly connects to the desired supports and outcomes of individuals, their families and key supporters, and which is informed by their rights for personal choice, dignity and control in service settings.

64. Consumer Representative, WAAMH Sector Strategic Framework Steering Committee

65. Department of Health 2010. South Australia's Mental Health and Wellbeing Policy: 2010-2015. Department of Health: Government of South Australia. http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/policies/sahealthmentalhealthandwellbeingpolicy-conspart-sahealth-30062010 [20 August 2013]

66. Ibid

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The CMMH sector, the MHC, together with individuals, their families and key supporters, are working in partnership to develop and implement a quality framework. Its purpose is to establish mechanisms to measure and report on the quality of services provided by the CMMH sector against the Mental Health Outcome Statements and the National Standards for Mental Health Services ('NSMHS'). The NSMHS sets the minimum standards of service for the CMMHS and provides clear information for service providers, individuals, their families and key supporters. The development of outcome statements by the MHC was another important step in describing the benefits or results of services. Thinking about how these outcomes, and other components of quality will be measured is in the development phase at both a state and federal level.

The objective of the quality framework is to build a culture of continuous service improvement so individuals, their families and key supporters experience high quality services and a better quality of life.

The objective of the quality framework is to build a culture of continuous service improvement so individuals, their families and key supporters experience high quality services and a better quality of life.

To date, the proposed quality management framework includes:

- an annual assessment completed by organisations, with a 12 month continuous improvement plan against the National Mental Health Standards;
- improved reporting, tracking, management and investigation (as required) of notifiable incidents by organisations; and
- evaluations conducted by a panel of independent evaluators (including people with a lived experience as an individual, carer and/or family member).

A comprehensive overview of a broader Quality Assurance Framework, including WA Health services, is beyond the scope of this document. Readers are referred to two reports, written by Gregor Henderson on behalf of the MHC at www.mentalhealth.wa.gov.au/mentalhealth_changes/quality

5 / The path forward

This paper has:

- Described the key principles and processes that support better lives for individuals, their families and key supporters
- Outlined the Commonwealth and State policy context shaping the direction of community managed mental health services now and into the future
- Identified the current investments and the investment intentions of governments in developing and expanding CMMH services in Western Australia
- Introduced a framework by which CMMH services can effectively engage with the change agenda

Our intention in writing this report has been to envision together what a better future for individuals, their families and key supporters could look like and what it might take for the CMMH sector to make this happen. We have chosen not to prescribe a plan for the sector but instead prepare a framework to assist the CMMH sector to contribute to a better future.

Stepping up to this work will require leadership by people who are tenacious and determined to make the changes required. It will require partnerships across communities with a wide range of stakeholders and a willingness to share intellectual property, skills and learning. It will also require a recognition that wisdom comes not just from those with formal status or education but from individuals who have much to share about personal recovery, from families and key supporters, peer workers, health workers and people from within and outside the sector.

Now is the time to take action. If, as a sector we are in any doubt about the importance of change, we need only ask those who use our services (or more importantly those who choose not to). If we are not sure where to start or what issues should be prioritised, given the complexities we face, individuals, their families and key supporters will tell us. An important ingredient for successful change is a widely held perception throughout an organisation about what needs to change and why. Full, active and sustained executive support will be required along with the engagement of employees, individuals, their families and key supporters.

WAAMH will work closely with the sector as it builds on this framework and support the sector in taking on this challenge by:

- Making the framework and the related tools widely available as a resource for CMMH services
- Increasing the development activities and resources open to CMMH services to progress the key elements of leadership, governance and cultural change identified in this report.
- Providing access to partnership resources to the sector, including WAAMHs web-based partnership resources kit and service directory.
- Progressing workforce development in the sector, including foundation recovery based community mental health training and a strategy to develop a vibrant peer workforce.
- Making specific development opportunities available to the sector to support person-centred practice, self-direction and recovery.
- Supporting the sector in continuous quality improvement through outcome measurement and standards assessment.

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Appendix A: Steering group & project consultants

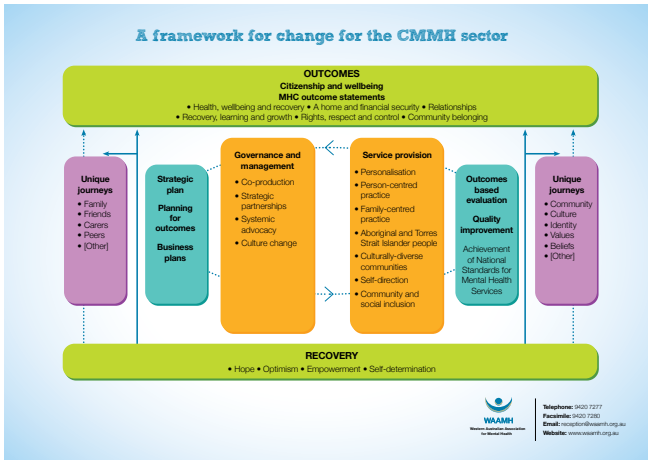
Steering group members:

Marita Walker	(Chair) CEO, Perth Home Care Services, Vice President WAAMH
Rod Astbury	Executive Director, WAAMH
Jacqui Bell	Policy and Sector Development Manager, WAAMH
Rhianwen Beresford	Consumer Representative, Project Officer, Consumers of Mental Health WA
Joe Calleja	CEO, Richmond Fellowship, Board Director WAAMH
Margaret Doherty	Carer Representative, Convener, Mental Health Matters 2
Tammy Ford	Assistant Director Quality Improvement and Sector Development, MHC
Pam Gardner	Regional/Rural Representative, Board Director, Bay of Isles Community Outreach, Board Director WAAMH
Kerry Hawkins	Carer Representative, Board Director WAAMH
Reg Henry	Aboriginal Representatives, Culture and Workforce Development Senior, Ruah Community Services
Elaine Patterson	Director Service Purchasing and Development, MHC
Susan Nye	Sector Development Manager, WAAMH

Project consultants:

Group Institute International Caryl Bailey and Martin Ringer

Appendix B: A3 poster thumbnails



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