phn MURRAY

An Australian Government Initiative

PART B
PROGRAM SPECIFIC INFORMATION

PSYCHOSOCIAL RECOVERY SERVICES

(REVISED JANUARY 2022)

Leadership | Collaboration | Knowledge | Innovation | Accountability

About these guidelines

This document provides guidance for health services commissioned by Murray PHN to deliver psychosocial recovery for people in the Murray PHN catchment. It outlines the scope, eligibility requirements, clinical governance obligations and workforce requirements specific to the provision of Psychosocial Recovery Services.

This document must be read in conjunction with Part A – Program Guidelines and Part C – Data Capture and Reporting Specifications.

Psychosocial Recovery Services commissioned by Murray PHN represent part of the overall service system. As such, commissioned services are expected to ensure that service delivery and care are integrated and coordinated into the regional and/or local service system, and supported by clear referral pathways and options necessary to provide consumers with the right care, in the right place, at the right time.

This is a revised, newly structured version of the Murray PHN Psychosocial Recovery Program guidelines. These guidelines have been informed by feedback and ongoing collaboration with commissioned health services, consumers and other partners of Murray PHN, and by priority areas and PHN funding guidance from the Australian Government.

In addition, relevant state and national practice and accreditation standards, clinical governance and service frameworks and legislative requirements have been used to guide and inform these program guidelines.

For further information or clarification about any information outlined in this document, please contact:

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Murray PHN acknowledges the Traditional Owners of the land on which we work and live. We recognise, celebrate and respect Aboriginal and Torres Strait Islander people as the First Australians.

We acknowledge their unique cultural and spiritual relationships to the land and waters, as we strive for healing, equality and safety in health care.

We pay our respects to their elders past, present and emerging, and extend that respect to all First Nations peoples.

Part B: Psychosocial Recovery Services contents

Version	Document Title	Date released	Prepared by	Approved
3	Murray PHN Primary Mental Health Program Guidelines	June 2019	A Bonsey	P Wilkinson
4	Murray PHN Psychosocial Recovery Services Program Guidelines	September 2020	T Moriarty	E Reid
5	Murray PHN Psychosocial Recovery Services Program Guidelines	July 2021	S Green	J Rasmussen
6	Murray PHN Psychosocial Recovery Services Program Guidelines	January 2022	S Green	I Johansen

1 Introduction

Primary Health Networks (PHNs) have been funded by the Department of Health to provide a regional, stepped care approach to commissioning of Psychosocial Recovery Services under the Commonwealth Psychosocial Support Program.

Psychosocial Recovery Services (PRS) aim to address gaps in service provision for people who are unable to access the National Disability Insurance Scheme (NDIS), but whose recovery would benefit from receiving specialist psychosocial supports.

Services must be delivered in line with these guidelines and form part of the contractual obligations associated with entering into an agreement with Murray PHN.

1.1. Background

The NDIS provides a new framework for the provision of support services for people who have or are likely to have a permanent disability that results in a significant functional impairment. The NDIS is funded by the Australian Government and 14 per cent of NDIS support recipients are expected to have a primary disability type of a 'Psychosocial Disability' at full scheme[1].

Murray PHN funded psychosocial recovery programs are intended to support people who are not eligible for the NDIS or who have not yet had their eligibility confirmed.

2 Service principles and approaches

2.1. Stepped care

Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, that can be matched to the individual's needs[2]. Stepped care recognises there is a spectrum of needs, and therefore, also requires a spectrum of services across mental health, psychosocial recovery and alcohol and other drug services. Stepped care is a different concept from 'step up/step down' services. While there are multiple levels in a stepped care approach, they do not operate in silos or as one-directional steps, but rather offer a continuum of service interventions, matched to the spectrum of mental health need. This spectrum and the levels of care associated with it at a population level are illustrated in Figure 1.

A stepped care approach promotes person-centred care that targets the needs of the individual consumer. Rather than offering a 'one size fits all' approach, individual consumers will be more likely to receive a service that optimally matches their needs, does not under or over service them and makes the best use of workforce and technology. A stepped care approach provides the right care at the right time, at the right place, with lower intensity steps available to support individuals before illness manifests.

2.2. A coordinated and integrated system of care

Psychosocial Recovery Services must be integrated with other relevant service partners that support consumer wellbeing and recovery outcomes. Key service partners should include:

- Other PHN stepped care funded primary mental health and alcohol and drug services
- Area mental health services
- Early Intervention Psychosocial Support Response (EIPSR) services
- Community health services
- General practice
- Employment, financial and housing services
- Community social groups
- NDIS and their Local Area Coordinator partners.

Figure 1 – Stepped care and levels of need

2.3. Service aims

All Murray PHN funded Psychosocial Recovery Services are aimed at assisting consumers to recover from the impacts of mental illness and:

- Building consumer capacity and connectedness at times when it is most needed
- Fit within a regional stepped care approach
- Deliver flexible and integrated services
- Link to clinical services and care coordination.

2.4. Service scope

Psychosocial Recovery Services must be delivered:

- Only to eligible consumers in the Murray PHN region
- In a way that is complementary, and not in duplication to other services such as NDIS or state-funded psychosocial support services.

Psychosocial services include a range of non-clinical supports that focus on building capacity and stability in the following areas:

- Social skills, social connectedness and friendships to reduce isolation
- Family connections
- Managing daily living needs
- Increasing engagement in daily activities, relationships and the community
- Financial management and budgeting
- Finding and maintaining a home
- Vocational skills and goals, including volunteering
- Educational and training goals
- Maintaining physical wellbeing, including exercise
- Improving or stabilising mental health and wellbeing
- Managing drug and alcohol addictions, including tobacco
- Building broader life skills including confidence, independence and resilience
- Building capacity to live independently in the community
- Reducing the need for acute mental health services
- Move towards personal recovery goals
- Support access to appropriate supports including the NDIS where appropriate.

Services must not:

- Be clinical in nature
- Be delivered to manage or respond to crises
- Expect support workers to be the pathology, deficits and dependency. There is no single description or definition of recovery because recovery is different for everyone. However, central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also, key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination.

Some characteristics of recovery commonly cited are that it is:

- A unique and personal journey
- A normal human process
- An ongoing experience and not the same as an end point or cure
- A journey rarely taken alone
- Nonlinear and therefore frequently interspersed with both achievement and setbacks.

The personal view of recovery is as a journey that is a unique and personal experience for each individual. It has often been said to be about: gaining and retaining hope, understanding of one's abilities and limitations, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. Essentially, the personal view of recovery is about a life journey of living a meaningful and satisfying life[4]. Figure 2 depicts the concept of recovery, central to the delivery of Psychosocial Recovery Services.

Figure 2 - The Concept of Recovery[5]

2.5. Recovery

The concept of recovery was conceived by, and for, people with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of diagnosis. The recovery movement began in the 1970s, primarily as a civil rights movement aimed at restoring the human rights and full community inclusion of people with mental health issues[3]. Recovery approaches are viewed by the consumer movement as an alternative to the medical model which has its emphasis on services.

Service provider recovery approaches will be different depending on where a person is in their recovery journey.

During an acute phase of illness, the person's capacity may be impaired to the extent that alleviation of distress and the burden of symptoms, as well as safety, are the primary focus of treatment and care. Regaining capacity for self-determination or deeper engagement should be a focus in the next stage of treatment and support. At later stages, when capacity is improved, there are opportunities for the person to consider broader recovery strategies.

Murray PHN funded organisations will have a commitment to working within a recovery-oriented framework. Programs will be delivered by a workforce trained in the principles and practice of recovery-oriented care.

2.6. Recovery-oriented domains of need

The National Framework for Recovery-oriented Mental Health Services[6] provides a set of capabilities grouped into five practice domains that outline expectations for service delivery. Murray PHN expects service providers to embed recovery-oriented practice capabilities outlined in the recovery domains. These domains are listed in brief below, however, please refer to full descriptions of the National Framework recovery-oriented capabilities and domains.

Domain 1 - Promoting a culture and language of hope and optimism	The service provider culture and language of recovery-oriented practice and service delivery ensures consumers feel valued, important, welcome and safe, and communicates positive expectations and promotes hope and optimism.
Domain 2 - Person first and holistic	The service provider places consumers who experience mental health issues first and at the centre of practice and service delivery, viewing a person's life situation holistically.
Domain 3 - Supporting personal recovery	The service provider ensures practice and service delivery is personally defined and led, and recovery is at the heart of practice rather than an additional task.
Domain 4 - Organisational commitment and workforce development	The service provider, service and work environment and organisational culture are conducive to recovery and to building a workforce that is appropriately skilled, equipped, supported and resourced for recovery-oriented practice.
Domain 5 - Action on social inclusion and social determinants of health, mental health and wellbeing	The service provider upholds the human rights of people experiencing mental health issues and challenging stigma and discrimination, advocating to address the poor and unequal living circumstances that adversely impact on recovery.

2.7. Service delivery principles

Psychosocial Recovery Service providers are expected to tailor their service and practice delivery models to best meet the needs of the client group in their region. Service delivery should be:

- **Recovery oriented** and operate under a recovery framework by increasing choices and opportunities for consumers to live a meaningful, satisfying and purposeful life
- **Strengths-based** and focus on the strengths, abilities and resources of consumers to build resilience and increase capabilities and wellbeing through social and environmental opportunities
- **Consumer focused** and address the specific support requirements and goals of an individual, while building on strengths to empower consumers to take an active role in their recovery journey
- **Inclusive of carers** and ensure services recognise and value the role of carers in support of people with a lived experience of mental illness
- **Culturally appropriate** and delivered in ways that are culturally appropriate, safe and relevant
- **Trauma informed** and delivered under a trauma informed framework promoting safety, trust, choice, collaboration, respect and empowerment
- **Flexible in delivery** and therefore may operate differently from region to region as service providers tailor their service delivery model to best meet the needs of the consumer group in their region
- **Complementary** to existing service systems and work within the context of locally available services and supports to complement existing service systems
- **Collaborative** in their approach and build and maintain strong linkages and partnerships with local clinical and social/human services to streamline referral pathways and facilitate services for consumers. In addition, planning and delivery of programs and services should be conducted in partnership with consumers and their families and/or carers.
- **Clinically embedded** and ensure consumers receive every available opportunity to improve their mental health outcomes. Service providers are expected to support consumers to access clinical services and engage in a multi-agency care approach to ensure integrated and holistic service delivery.

3 Recovery support programs

3.1. Psychosocial support

The Department of Health defines psychosocial support as those supports and services that are provided or purchased to work in partnership with individuals who are not more appropriately funded through the NDIS and are significantly affected by severe mental illness, which has an impact on their associated psychosocial functional capacity. These services, in partnership with families and carers (as appropriate), provide a range of non-clinical community-based support to these individuals to achieve their recovery goals[7].

3.2. Service elements

Service delivery approaches should observe the following key service elements:

- Be delivered according to the PRS Client Journey Flow Chart (see Appendix 1)
- Include assessment, recovery action planning, crisis planning and three-monthly case review
- Offer individual, group-based, outreach and place-based interventions in accordance with consumer need
- Offer a range of support modalities such as face-to-face, telephone and online options in accordance with consumer preference
- Offer service navigation support, where appropriate. Service navigation provides people with information and referral to appropriate services that are locally available to meet their social, mental and physical health needs.

4 Service provider obligations

4.1. Referrals

Referrals may come from several sources including self-referral, GP/medical practitioner, support workers or family/carers. Eligible referrals will be accepted from any source (with consent). Providers must actively promote the service in their region.

Providers should establish coordinated referral pathways to support consumer access to psychosocial, clinical and primary health services. Carers and family members should also be provided with support information and referral as required.

4.2. Eligibility

To be eligible for Psychosocial Recovery Services, a consumer must:

- Have a severe mental illness that has an impact on their psychosocial functional capacity
- Be 16 years of age and over
- Have needs that can be appropriately met within 3-12 months, low intensity support.

Consumers who are eligible for the NDIS and state-funded psychosocial supports should be supported to access these programs where appropriate.

4.3. Consumer consent

Service providers are required to have established processes to ensure consumer consent is gained to support the:

- Provision of services/interventions to the consumer
- Sharing of information with the consumer's GP, referring practitioner and/or referrals to other key service provider partners
- Sharing of de-identified information with Murray PHN and the Department of Health for the purposes of service reporting and evaluation.

4.4. Intake and demand waitlist management

Service providers must have a demand management strategy and processes in place to manage service access and risks of individuals referred to them. This should include active waitlist management and a single consolidated and centralised system for recording and tracking all referrals from the date of referral to the date of discharge.

In addition, where relevant, other requirements contained in Section 5.2 Demand and Waitlist Management - Part A Program Guidelines must be met.

4.5. Intervention types

Service providers are expected to use interventions that have an evidence-base for success in addressing the domains of need. Such interventions must focus on building ability and skills to assist consumers to manage their mental illness, improve their relationships with family and others, and increase social and economic participation in their communities. Service providers must also aim to deliver (either directly, or in partnership with other local services):

- Social skills training
- Supported employment
- Supported education
- Supported housing
- Family psychoeducation
- Outreach services
- Cognitive remediation
- Support self-management of illness/es
- Physical health management (including support to access physical health assessments and treatment)
- Service navigation
- Care coordination
- Peer support/consumer networking.

Table 5 outlines recommended and evidence-based approaches that are best suited to supporting consumer psychosocial needs, as identified by Hayes and colleagues in Effective, evidence-based psychosocial interventions suitable for early intervention in the NDIS: promoting psychosocial functioning and recovery (2016)[8].

Note: Service providers may refer consumers to clinical services for the provision of evidence-based psychological interventions included in this table.

Table 5 – Intervention types (Priority of needs identified by people living with Severe Mental Illness - Hayes et al. 2016)

Need	1	2	3	4	Recommended and evidence-based interventions (EBIs) to meet relevant need
Uncontrolled symptoms	✔	✔	✔	✔	Family psycho-education, cognitive behavioural therapy (CBT) for psychosis, illness self-management training, peer support, cognitive remediation
Loneliness/ social isolation	✔	✔	✔	✔	Social skills training, family interventions, employment programs, supported housing
Financial	✔	✔		✔	Employment programs, illness self-management, individual psycho-education, supported housing
Lack of employment/ daytime activities	✔	✔	✔		Employment programs, cognitive remediation, social skills training, family interventions
Physical health	✔	✔		✔	Health services engagement supports, consumer education
Suitable housing	✔	✔		✔	Housing programs, social skills training
Need for family or carer support	✔			✔	Family psycho-education and support, multisystemic therapy (MST) or acceptance commitment therapy (ACT), outreach
Stigma and discrimination	✔				Social skills training, family interventions, social cognition training, employment programs
Access to mental health services	✔				Case management and service coordination, MST or ACT, outreach
Distress			✔		Case management and service coordination; MST or ACT/outreach; CBT for psychosis; illness self-management training; hearing voices.
Information			✔		Health services engagement supports, health lifestyle programs and education, CBT for psychosis, illness self-management training

Key			
1 - Morgan et al. 201	2 - Killacky et al 2015	3 - Thornicroft et al. 2004	4 - Brophy et al. 2015

4.6. Assessment, outcome measures and recovery care plans

Murray PHN expects service providers to undertake a comprehensive assessment of the psychosocial needs of the consumer. This process needs to occur in collaboration with the consumer and any nominated (by the consumer), relevant others. In addition, there are a number of assessment and outcome measure tools that service providers can use to support assessment, care plan review, service evaluation and program exit/discharge processes.

Assessment and outcome measure tools are administered at the commencement of service/intake, at the three-monthly case reviews and three-monthly intervals in the instance supports extend beyond six months, and again at exit from service. This will inform the time period for which a person may access the program. The Recovery Assessment Scale - Domains and Stage (RAS-DS) should be the primary assessment tool used. This does not preclude use of other outcome measure and assessment tools.

Recovery is not a linear journey and a reduction or increase in RAS-DS scores over time (total or individual items) need to be interpreted collaboratively with consumers themselves.

As part of the assessment process the Your Experience of Service (YES) survey should be offered. Formal, real-time feedback to clinicians from consumers has proven to result in significant improvement in both retention and outcomes. Feedback should continue to be captured on a routine basis throughout the client's journey. See resource: Using formal client feedback to improve retention and outcome_Miller 2006.pdf

The YES survey was developed as a result of the Commonwealth Government's Department of Health's National Consumer Experiences of Care (2010) project. It has been designed for use in mental health services and has been specifically updated to include a version for use by PHN commissioned service providers. Service providers must administer the YES survey to the consumer at least once at discharge/exit from service and are expected to use data/information collected to inform service review, continuous quality improvement and service evaluation.

Note: Consumers who have accessed services through health navigators should be offered the YES survey. They can complete this online at the following link or download a paper version: transitionsupport.com.au/service-navigator/survey.php

Note: details for data reporting requirements at case closure/exit are contained in Part C – Data Capture and Reporting Specifications.

Other assessment and outcome measure tools include:

- Camberwell Assessment of Need Short Assessment Scale (CANSAS)
- Life Skills Profile (LSP-16)
- Kessler Psychological Distress Scale (K10 or K5)
- Service providers may choose to use the Initial Assessment and Referral (IAR) tool to support their intake assessment, however this is not mandatory[1]
- Recovery Star Assessment Tool.

Based on the assessment process and tool used, service providers are expected to develop, in collaboration with the consumer, a **Recovery Care Plan** that outlines the following:

- The consumer's strengths and existing supports
- The consumer's recovery goals and support needs
- Strategies, activities and interventions to achieve recovery goals and meet support needs
- Other service provider partners (including clinical) who may be referred to and used if/as required
- A crisis care plan in the event the consumer becomes unwell and/or a crisis occurs.

4.7. Consumer case review

It is expected that service providers will undertake a regular review of consumer care and recovery goals at the **three-month interval** of care and these should be used to track progress and inform exit planning. However, where indicated (such as in a crisis), review of consumer care would occur more frequently. At every occasion that consumer care is reviewed, a concurrent review of the consumer care plan and recovery goals must occur.

4.8. Recording and reporting

Psychosocial Recovery Services providers must have a Client Information Management System capable of:

- Secure capture and storage of consumer information
- Providing reports that meet Murray PHN specifications.

Providers must also report in line with the Primary Mental Health Minimum Dataset (PMHC-MDS) and the specifications and requirements for this are contained in Part C – Data Capture and Reporting Specifications.

4.9. Service duration

Supports should be provided under a recovery-framework and should seek to provide positive consumer outcomes within an agreed period. The RAS-DS can be used to define this period. It is anticipated that most consumers will have an initial support period of between three and six months if they do not have a severe and persistent mental illness, with additional support provided if deemed appropriate, following a support plan review.

Consumers requiring more intensive support services for a period greater than 12 months should be encouraged to test for NDIS eligibility. Where a consumer disengages from the program or cannot be reached, attempts should be made to contact them and offer additional or alternative supports. If the consumer cannot be reached after a period of three months and after at least three contact attempts in this time, the consumer should be formally exited from the program. If there is permission to contact a family member/carer, then it would be appropriate to contact that family/carer prior to exit from the program. Soft re-entry points should be established to enable streamlined re-entry to supports as required.

4.10. Flexible funds

Flexible funding is available to support PRS consumer recovery needs. Murray PHN recognises that some consumers will require greater funding support and some less. Providers must seek prior approval from Murray PHN for any spending exceeding $300 for any one consumer per financial year. The following criteria apply for use of the funds:

- Expenditure is in line with the individual's recovery goals as identified in their Recovery Care Plan
- Expenditure is in line with the aims and objectives of the PRS program
- Funding is used to purchase services, supports or goods on a short-term, ad-hoc basis to meet immediate need
- Services, supports or goods purchased with the flexible funding pool are capable of withstanding public scrutiny, and will not bring the PRS service providers or Murray PHN, into disrepute
- PRS Flexible funding should only be used when all other appropriate funding options have been explored
- Ensures adequate funding is available within the flexible funding budget to meet the needs of other PRS participants.

The purchase of goods and services using flexible funding should be evaluated according to the following criteria:

- **Quality history** - ability to provide goods and services consistently in accordance with quality requirements
- **Value for money** - best value for money being the benefits achieved compared to the whole of life costs. This includes price, quality, reliability, service, delivery, payment terms and strategic suppliers
- **Conflict of interest** – policies and procedures should be developed and implemented to mitigate any potential conflict of interest and ensure that clients have choice and control as to how funds are spent
- **On time delivery** - ability to provide goods and services within stated and agreed timeframes. The delivery of goods and services should be benchmarked against industry standards, wherever possible, and will be reviewed based on reliability and service performance
- **Financial stability** – capacity to provide goods and services from a business continuity perspective
- **Service performance** - ability to meet client need.

Service providers will be responsible for ensuring that the details of flexible funding expenditure are recorded and reported in a format specified by Murray PHN.

4.11. Service exit

Consumers will exit services for a variety of reasons including:

- Achievement of recovery goals
- Psychosocial support services no longer required
- Consumer re-location
- Consumer steps up to more intensive clinical services (acute in-patient mental health care)
- Support needs are outside scope of psychosocial supports
- Consumer is no longer eligible.

Service providers are expected to ensure consumers exiting from programs transition safely to alternative supports/services and a transition/exit plan is collaboratively developed to support this occurring.

When consumers are exiting a Psychosocial Recovery Support Program, service providers must also:

- Undertake/administer the RAS-DS
- Inform the referrer and/or the GP and provide them with a Summary of Care
- Offer the consumer the Your Experience of Service (YES) survey.

5 Governance

Murray PHN expects that all commissioned service providers have a clinical governance framework *(in keeping with the ACSQHC and Safer Care Victoria definitions and frameworks)* in place that also incorporates the Murray PHN Clinical Governance Domains outlined in the Part A Program Guidelines document. Service providers are also required to uphold the ACSQHC Safety and Quality Goals for Health Care (2013)[9] and maintain up-to-date clinical and practice policies, aligned with the ACSQHC National Standards (2017).

Service providers must comply with the clinical governance requirements outlined in Part A Program Guidelines. This includes the expectation to have established **management and supervision** mechanisms in place for all staff (including clinical supervision for relevant professions). Governance arrangements must also be in place to ensure that PRS flexible funding is spent responsibly and in line with the section on Flexible Funds (4.11) of these guidelines.

6 Workforce

Direction has been provided from consumers, carers and other stakeholders as to the specific qualities of the workforce. For the delivery of Psychosocial Recovery Support services, providers must recruit and retain a stable and workforce that is:

- Consistent
- Skilled
- Knowledgeable
- Genuine
- Culturally safe.

A component of service delivery from each provider must be from mental health peer support workers. Workers (whether peer or non-peer) should have a minimum base salary of $65,000 per annum (this applies to peer and non-peer workers).

In addition, to ensure a high-quality standard of service delivery, staff engaged to deliver services under funded programs must:

- Be appropriately qualified according to the requirements of their role, position description and discipline specific scope of practice
- Where required, have currency of registration with state or national practicing authorities and demonstrate evidence of the continuing professional development requirements
- Where appropriate, have membership with their discipline specific professional association
- Agree to abide by their discipline specific professional Code of Ethics and Code of Conduct
- Where required, have currency of accreditation/ credentialing to practice with their discipline specific professional association
- Have a working knowledge and be able to demonstrate compliance with relevant discipline specific professional practice standards and competency standards requirements.

Murray PHN also expects that the service provider workforce will undertake annual and other ongoing professional development education according to registration and discipline-specific and service provider role requirements. It is also expected that at a minimum, service provider staff will have knowledge and capacity to work in a recovery-oriented and trauma-informed framework.

6.1. The peer workforce

The peer workforce refers to both consumer and carer peer workers. **Consumer peer support workers** apply their personal lived experience of mental illness and recovery in supporting consumers. **Carer peer workers** apply their experience from caring and supporting family or friends with mental illness in supporting other carers and family members. Both consumer and carer peer workers play a valuable role in supporting the primary care team. Peer work is a professional role that is distinguished from other forms of peer support by the intentionality, skills, knowledge and experience that peer workers bring to their role.

Peer support workers are employed as professional subject matter experts and can be employed for the expertise developed from their personal lived experience of mental illness, alcohol and other drug disorders and recovery or their experience as a mental health carer, and can be a key conduit between a consumer, their carers and other services they use.

The inclusion of peer support workers in the primary mental health, Psychosocial Recovery Services care teams can help to improve the culture and recovery focus of services and help to reduce stigma within the workforce. Appropriate supervision and mentoring should be provided, including support from other experienced peer workers, and clinical support from other team members.

It is an expectation that service providers will have a component of peer support workers in their workforce for the delivery of Psychosocial Recovery Services. This should be a minimum of 0.2 for each 1.0 Full Time Equivalent.

6.2. Workforce and other resources

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- Department of Health (2013): A National Framework for Recovery Oriented Mental Health Services
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- National Mental Health Commission mentalhealthcommission.gov.au
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- Slade et al. (1999) CAN: The Camberwell Assessment of Need researchintorecovery.com/adultcan
- Slade et al. (2009) Personal Recovery and Mental Illness: A Guide for Mental Health Professionals. Cambridge: Cambridge University Press https://www.cambridge.org/core/books/personal-recovery-and-mental-illness/BD380E32B3A8D987546E61DEC76EE8FF
- The Fifth National Mental Health and Suicide Prevention Plan (2017)
- Mental Health Professional Online Development (MHPOD): MHPOD is an evidence-based online learning resource for people working in mental health. Currently, there are more than 100 hours of material across 68 topics, written and produced in Australia. The topics range from recovery to legislation and dual disability. Each topic includes an overview, activity, in-practice section, and resources such as checklists, templates, or links to further information. The content of MHPOD is linked to the National Practice Standards for the Mental Health Workforce.

7 References

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4. NSW Consumer Advisory Group (2012)
5. National framework for recovery-oriented mental health services: Guide for practitioners and providers 2013 1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra
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7. Department of Health Psychosocial Support for People with severe mental illness 1.health.gov.au/internet/main/publishing.nsf/Content/psychosocial-support-mental-illness
8. mindaustralia.org.au/sites/default/files/publications/Effective_evidence_based_psychosocial_interventions_full_report.pdf
9. Intake Assessment and Referral Decision Tool IAR - DST
10. Australian Commission on Safety & Quality Goals for Health Care 2013 safetyandquality.gov.au/sites/default/files/migrated/Goals-Overview.pdf

Appendix 1: Psychosocial Recovery Services client journey flowchart