



Australian Government
Department of Health and Ageing

PATHWAYS OF RECOVERY

Report of the National Consultation on Preventing Further Episodes of Mental Illness

Prepared for the National Mental Health
Promotion and Prevention Working Party

November 2005

Debra Rickwood
University of Canberra

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Online ISBN: 0 642 82932 2

Publications Approval Number: 3841

This report is available from <http://auseinet.flinders.edu.au>

This report was funded by the Australian Government Department of Health and Ageing and developed for the National Mental Health Promotion and Prevention Working Party, which exists under the auspices of the Australian Health Ministers' Advisory Council National Mental Health Working Group and the National Public Health Partnership.

Suggested citation for this report:

Rickwood D, Mitchell S (2006). *Pathways of Recovery: Report of the National Consultation on Preventing Further Episodes of Mental Illness*. Commonwealth of Australia, Canberra.

FOREWORD

This report, and the national consultation that it describes, has heightened awareness of the core role of prevention in continuing care for people who have experienced mental illness. The consultation was based around the *Discussion Paper* developed for the National Mental Health Promotion and Prevention Working Group on the role of relapse prevention in the recovery process for people seriously affected by mental illness. Through the consultation process, it was made very clear that preventing further episodes of illness is a fundamental concern of consumers and carers, although many consumers preferred the more wellness-focussed term “staying well” to the more illness-focussed term “relapse prevention”. Prevention is also a high priority of many service providers, particularly psychosocial and rehabilitation service providers, yet the fragmentation of the current mental health system works against this longer-term approach to wellness and continuing care.

This report summarises the national consultation and highlights the concerns of consumers, carers and service providers regarding the capacity of the current mental health system to deliver continuing care. There must be a fundamental reorientation from a crisis focus to a more proactive approach that can intervene early to prevent the development of crisis situations. While there is a lot of activity in the area of recovery-oriented services, it is evident that these approaches must be incorporated as part of routine practice in all mental health service delivery.

It is hoped that raising these issues through the consultation will encourage all jurisdictions to focus on better approaches to continuing care; approaches that operate with a recovery orientation and that incorporate ongoing prevention and psychiatric rehabilitation as part of core business within the mental health system. The national consultation reported strong support for the implementation of the 4As Framework presented in the *Discussion Paper* to ensure that jurisdictions develop the mental health service system to provide appropriate follow-up and continuity of care for people who have been seriously affected by mental illness.

Keith Wilson

Chair, Mental Health Council of Australia

EXECUTIVE SUMMARY

This report describes the national consultation that was undertaken in 2004 to provide stakeholders with an opportunity to comment on the discussion paper on the role of relapse prevention in the recovery process for people who have been seriously affected by mental illness.

The discussion paper and subsequent reports were funded by the Australian Government Department of Health and Ageing and developed for the National Mental Health Promotion and Prevention Working Party, which exists under the auspices of the Australian Health Ministers' Advisory Council National Mental Health Working Group and the National Public Health Partnership.

This report describes both the consultation process and the feedback generated.

Aims of the consultation

The National Mental Health Promotion and Prevention Working Party (PPWP) developed a discussion paper on the role of relapse prevention in the recovery process for people seriously affected by mental illness entitled, *Pathways of Recovery: The role of relapse prevention in the recovery process for people seriously affected by mental illness (2004) [Discussion Paper]*. The *Discussion Paper* was developed through a consultation process and was designed to encourage widespread discussion of issues related to relapse prevention and consideration of ways to ensure that relapse prevention becomes a routine part of continuing care within Australia's mental health care system.

PPWP wished for all stakeholders to be given an opportunity to comment on the *Discussion Paper*. To enable this, a national consultation was undertaken across all States and Territories to ensure that consumers, families and carers, service providers, and other stakeholders had the opportunity to give their views.

The consultations sought the following feedback:

- comments on the issues raised and the approach taken in the *Discussion Paper*;
- other issues or approaches that need to be considered;
- views on what is required to ensure that relapse prevention becomes a routine component of continuing mental health care and self-care; and
- comments on what is needed to support people and services to put this approach into practice.

Consultation process

The consultation was undertaken as a partnership between the researcher and writer of the *Discussion Paper*, Debra Rickwood, and Susan Mitchell from Auseinet (The Australian Network for Promotion, Prevention and Early Intervention for Mental Health and Suicide Prevention), members of the National Mental Health Promotion and Prevention Working Party, and the States and Territories.

There were three avenues through which feedback on the *Discussion Paper* could be provided:

- national face-to-face Consultation Forums held in each State and Territory;
- invited submissions from organisations with an interest in mental health; and
- an open invitation to comment posted on the Auseinet website.

The face-to-face Consultation Forums were the main approach used to gain feedback. A capacity building approach was used for engaging each of the jurisdictions to plan and develop their own Forum structure. Each jurisdiction was able to determine the nature, site, participants and the local contextual content of their face-to-face forum(s). This enabled jurisdictions to utilise existing infrastructure and to take into consideration local issues.

Invited submissions were sought from over 50 organisations and individuals who have an interest in relapse prevention. Written or interview submissions were received from 38 of these invitees.

An open invitation to comment was posted on the Auseinet website. The *Discussion Paper* and a *Summary Version* were able to be downloaded from the site and comments could be sent to a dedicated email address.

Consultation forums

There were 21 Consultation Forums held across Australia during 2004. These engaged 653 participants representing a range of sectors including consumers, carers, mental health, non-government organisations (NGOs), psycho-social support services, education, health promotion, drug and alcohol, community and academia.

The Consultation Forums had a variety of formats, but all included an overview of the *Discussion Paper* and small group workshops to gather feedback. Many jurisdictions also took the opportunity to showcase local initiatives and innovations in relapse prevention, recovery or rehabilitation.

The Consultation Forums were instrumental in raising awareness of the issue of relapse prevention and its role in recovery, and bringing together people with an interest in continuing care.

Feedback

Feedback on the *Discussion Paper* was mostly positive. The majority of people felt it was timely for the issue of relapse prevention to be discussed and liked the approach taken in the *Discussion Paper*. The focus on consumer voices throughout the paper was seen as a particular strength. However, use of words such as ‘preventing further episodes of mental illness’ and ‘staying well’ were preferred to ‘relapse prevention’, and a more wellness and strengths-based focus was suggested.

The 4As Framework—Awareness, Anticipation, Alternatives and Access—was universally endorsed as being relevant, appropriate and easy to understand.

Generally, the *Discussion Paper* was reported to be comprehensive, although gaps were evident in content related specifically to people with more complex issues and co-morbidities, such as forensic populations, people with drug and alcohol problems, and people with disabilities.

It was argued that the *Discussion Paper* needed to be translated into a briefer framework to facilitate implementation. Implementation was a source of concern, with people feeling that

although relapse prevention should be a routine part of continuing care, the mental health system did not have the capacity to adequately incorporate it. Much of the mental health system remained crisis focussed and driven, and there was poor resourcing and integration of the essential elements of psychiatric disability, peer support and psycho-social community services sectors.

Future directions

The consultation gave rise to the following future directions:

- development of a summary framework for preventing further episodes of mental illness based on the 4As;
- development a range of education and training material and tools to help people to incorporate relapse prevention within treatment and continuing care;
- availability of practical information around key implementation strategies including easily accessible information on what was currently happening across Australian and internationally, and examples of best practice in relapse prevention interventions and programs; and
- revision of the *Discussion Paper* to reflect some of the concerns raised through the consultation.

CONTENTS

Foreword	iii
Executive Summary	iv
Contents	vii
Membership of the National Mental Health Promotion and Prevention Working Party	viii
1. Introduction	1
1.1 Background.....	1
1.2 Overview of the report.....	2
2. The National Consultation	3
2.1 Aims.....	3
2.2 Consultation process.....	3
<i>Phase 1: Development of the Discussion Paper</i>	3
<i>Phase 2: Implementation of National Consultation on Relapse Prevention</i>	5
3. Consultation Forums	7
3.1 A capacity building approach.....	7
3.2 Workshops to provide feedback.....	10
3.3 Overview of the Consultation Forums.....	10
<i>New South Wales</i>	11
<i>Victoria</i>	12
<i>Queensland</i>	13
<i>Western Australia</i>	14
<i>South Australia</i>	15
<i>Tasmania</i>	16
<i>Australian Capital Territory</i>	17
<i>Northern Territory</i>	18
4. Summary of Comments	19
4.1 Comments on the relapse prevention framework presented in the Discussion Paper.....	19
4.2 Other experiences of relapse prevention.....	21
4.3 Implementation.....	22
<i>Resources</i>	23
<i>Translating policy into practice</i>	24
<i>Reorientation</i>	24
<i>Attitudes, education and training</i>	25
<i>Applicability for diverse population groups</i>	26
4.4 How will we know that relapse prevention has become standard practice?.....	26
5. Future Directions	28
Appendix 1. Letter of invitation to comment sent to peak organisations and other stakeholders.....	29
Appendix 2. Questions for invitation to comment via Auseinet website.....	30

MEMBERSHIP OF THE NATIONAL MENTAL HEALTH PROMOTION AND PREVENTION WORKING PARTY

The National Mental Health Promotion and Prevention Working Party (PPWP) is auspiced by the Australian Health Ministers' Advisory Council National Mental Health Working Group and the National Public Health Partnership Group. The PPWP is comprised of members or nominees of these auspicing groups as well as representatives of other key stakeholder groups.

Professor Beverley Raphael (Chair)	Professor, Population Mental Health, University of Western Sydney
Ms Leonie Manns	Consumer representative Mental Health Council of Australia
Mr Keith Wilson	Carer representative Chair, Mental Health Council of Australia
Professor Steve Zubrick	Centre for Development Health, Curtin University of Technology, Institute for Child Health Research
Dr Diana Lange	Consultant Physician in Psychiatry and Public Health, Queensland, National Public Health Partnership
Mr Clive Skene	A/Director, Division of Mental Health, Flinders Medical Centre
Ms Pat Delaney	NSW Aboriginal Health and Medical Research Council
Dr Darcy Smith	Australian Divisions of General Practice
Ms Lyn Walker	VicHealth, Victorian Health Promotion Foundation
Dr Roscoe Taylor	Director of Public Health, Department of Health and Human Services, Tasmania
Mr Adrian Booth	Department of Health, South Australia
Ms Sue Brennan	Mental Health Branch, Department of Health and Human Services, Victoria
Ms Vicki Caudwell	Office of Mental Health, Department of Health, Western Australia
Ms Simone Caynes	Mental Health Unit, Queensland Health
Ms Bernadette Dagg	Manager, Promotion Unit, Centre for Mental Health, NSW
Ms Jennie Parham	Director, Australian Network for Promotion, Prevention and Early Intervention for Mental Health and Suicide Prevention
Ms Kerry Webber	Director, Suicide Prevention and Mental Health Promotion Section, Australian Government Department of Health and Ageing

Secretariat

Tracy Thompson, Suicide Prevention and Mental Health Promotion Section
Australian Government Department of Health and Ageing

1. INTRODUCTION

1.1 Background

A significant positive development in the mental health field is growing recognition that a diagnosis of mental illness is not a life sentence to an incurable condition that invariably will have only negative consequences for a person's life course. This was the view that, until recently, was commonly held by many consumers, their families and clinicians. While the onset of mental illness is undoubtedly a serious life event, many people who have experienced mental illness live full and meaningful lives: some remain symptom free after their first episode, while others adapt to the symptoms that they recurrently experience. It is now recognised that it is not inevitable that a first episode will lead to further illness and that even when further episodes do occur, it is not necessary for such illness to put an end to the positive aspects of life.

For people who have experienced a first episode of mental illness, the risk of future episodes is increased, however, and efforts to prevent recurrent episodes are essential to reduce the impact of mental illness for consumers, their families and carers, and their communities. Consequently, ways to prevent further episodes and reduce their impact on wellbeing have become a valuable area of investigation. A growing body of evidence attests that such prevention is possible.

Relapse prevention has been recognised as a high priority for some time. The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000)* [Action Plan 2000] acknowledged the importance of relapse prevention and early intervention for recurrent mental illness and identified these as areas for future action. It was noted in *Action Plan 2000* that many of the issues related to promotion, prevention and early intervention for mental health were also relevant to preventing relapse, but that there were likely to be unique factors for people who had already been diagnosed with a mental illness that warranted separate consideration in another document.

The *Evaluation of the Second National Mental Health Plan (2003)* reported that early intervention, for both first and recurrent episodes of mental illness, was an area where there was still considerable need for improvement in terms of Australia's mental health care system. Continuity of care, in all its forms—across the course of an episode of illness, across the lifespan, and across service sectors—was also an area where greater emphasis and innovative approaches were urgently required.

Most recently, relapse prevention is clearly evident in the *National Mental Health Plan 2003-2008* as an area that requires increased focus. Factors related to relapse prevention are emphasised throughout the *Plan*, particularly in the sections on preventing mental health problems, access to care, continuity of care, support for families and carers, consumer rights and legislation, and consumer and carer participation.

In response, the National Mental Health Promotion and Prevention Working Party (PPWP), which is auspiced by the Australian Health Ministers' Advisory Council National Mental Health Working Group and the National Public Health Partnership Group, developed a discussion paper entitled, *Pathways of Recovery: The role of relapse prevention in the recovery process for people who have been seriously affected by mental illness (2004)* [Discussion Paper]. Phase 1

of the consultation involved development of this *Discussion Paper* as well as a shorter *Summary Version*.

PPWP wished for all stakeholders to be given an opportunity to comment on the *Discussion Paper* and to provide input on ways that can help ensure that relapse prevention becomes a routine part of continuing care. This report summarises the process and outcomes of this consultation.

1.2 Overview of the report

This report documents the process of developing the consultation as well as the outcomes. The report is structured in the following way:

Section 2 provides an overview of the aims and objectives of the consultation and a brief description of the consultation strategies.

Section 3 provides an overview of the Consultation Forums, which were the main approach taken to the consultation. This section covers the capacity building approach to the development of the forums, an outline of the method used for the workshops in the Consultation Forums, and an overview of the process undertaken in each individual State and Territory.

Section 4 summarises feedback on the *Discussion Paper* gathered through the consultation.

Section 5 suggests some future directions, arising from the consultation, to progress this issue.

2. THE NATIONAL CONSULTATION

2.1 Aims

The principal aims of the national consultation were to:

- put the issue of relapse prevention firmly on the agenda for widespread discussion;
- provide an opportunity for all stakeholders to voice their views on the role of relapse prevention; and
- facilitate feedback to better understand how to implement relapse prevention within continuing care.

2.2 Consultation process

The National Mental Health Promotion and Prevention Working Party (PPWP) carried out this work on relapse prevention as another important aspect of their prevention and early intervention agenda. Consumer and carer voices, as well as previous work undertaken by PPWP on promotion, prevention and early intervention for mental health, argued for greater emphasis on relapse prevention and better understanding of its role in the recovery process for people seriously affected by mental illness.

To progress this understanding, Phase 1 involved the development of a discussion paper on the role of relapse prevention in the recovery process for people seriously affected by mental illness entitled, *Pathways of Recovery: The role of relapse prevention in the recovery process for people seriously affected by mental illness (2004) [Discussion Paper]*, and Phase 2 was a national consultation around this *Discussion Paper* and the issues it raised, and subsequent development of a framework for relapse prevention.

Phase 1: Development of the Discussion Paper

The first phase of the national consultation involved development of the *Discussion Paper*. It was imperative that this paper be based on and guided by the experiences of people with mental illness and their families and carers. It was also important that the views of service providers, who have the responsibility of providing clinical and non-clinical support to people with mental illness, be incorporated. Consequently, the methodology used to develop the paper was based on ensuring that the views of all these people were presented.

There were five main components to this phase, as shown in Figure 1. These components were undertaken in late 2003 and comprised:

- *Liaison with Auseinet and Auseinet Consumer and Carer Consultative Committee* — The Australian Network for Promotion, Prevention and Early Intervention for Mental Health and Suicide Prevention (Auseinet) was an important resource, providing networks and information. Of particular note, Auseinet's Consumer and Carer Consultative Committee provided essential guidance. This Committee comprised consumer and carer representatives invited from all States and Territories, with New South Wales, Victoria, South Australia, Western Australia, Tasmania and the Northern Territory represented at the time of developing the paper. These people helped to access consumer and carer networks

within each of the jurisdictions. Their personal experiences were also a valuable resource, and a focus group was undertaken with the members of the Consultative Committee prior to the other consultations to develop questions to promote useful discussion.

- *National consultation with consumers and carers* — Focus groups and interviews were conducted across Australia with male and female consumers of all ages and representing a cross-section of the community in terms of social, economic and cultural backgrounds, as well as their families and carers. Focus groups and interviews were generally taped and transcribed (after which the original tapes were erased) and direct quotes from these conversations are anonymously presented throughout the *Discussion Paper*. Focus groups and interviews were undertaken according to the principles outlined in the *National Statement on Ethical Conduct in Research Involving Humans* (NHMRC 1999). Furthermore, specific ethical issues related to undertaking research with mental health consumers were also taken into consideration (see Peterson 1999).
- *National consultation with service providers and other stakeholders* — The views of service providers, from both clinical and community support services, and representatives from peak mental health organisations were also obtained through focus groups and interviews conducted across Australia. Direct quotes from these conversations also are anonymously presented throughout the document.
- *Review of the national and international literatures* — A review of the national and international literatures related to relapse prevention was undertaken. This involved a search of relevant computerised databases, as well as resources provided by Auseinet and some of the stakeholders contacted during the consultation. The literature review was not intended to be exhaustive, but rather was used to provide a summary of the main issues that have been researched relevant to relapse prevention for mental illness.
- *Review of current State/Territory initiatives in relapse prevention* — Each State and Territory nominated a representative from the government mental health sector to provide information on current State/Territory initiatives related to relapse prevention. These representatives were personally contacted by phone and email to elicit information around current initiatives in each of the jurisdictions. This process aimed to develop an understanding of some of the major initiatives being undertaken that related to relapse prevention in each of the States and Territories, to provide a current Australian context to the *Discussion Paper*.

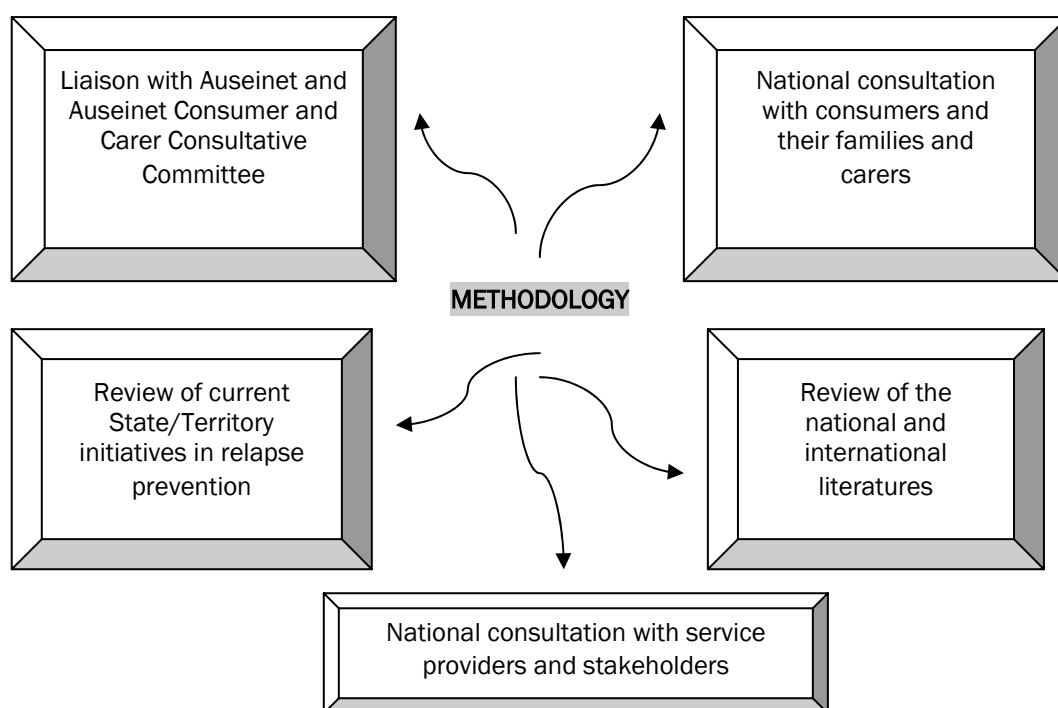


Figure 1. Methodology used to develop the *Discussion Paper*

Phase 2: Implementation of National Consultation on Relapse Prevention

The *Discussion Paper* was developed to provoke and inform broad discussion of issues related to relapse prevention and consideration of ways to ensure that relapse prevention becomes a routine part of continuing care within Australia's mental health care system.

PPWP wished for all stakeholders to be given an opportunity to comment on the *Discussion Paper* and to provide input on ways that can help ensure that relapse prevention becomes a routine part of continuing care. To enable this, a national consultation was undertaken across all States and Territories to ensure that consumers, families and carers, service providers, and other stakeholders had the opportunity to comment and give their views.

The consultation was undertaken as a partnership between the researcher and writer of the *Discussion Paper*, Debra Rickwood, and Susan Mitchell from Auseinet (The Australian Network for Promotion, Prevention and Early Intervention for Mental Health and Suicide Prevention), members of the National Mental Health Promotion and Prevention Working Party, and representatives from the States and Territories.

The consultation sought the following feedback:

- Comments on the issues raised and the approach taken in the *Discussion Paper*;
- Other issues or approaches that need to be considered to progress relapse prevention;
- Views on what is required to ensure that relapse prevention becomes a routine component of continuing mental health care and self-care; and
- Comments on what is needed to support people and services to put this approach into practice.

There were three avenues through which feedback on the *Discussion Paper* could be provided:

- national face-to-face Consultation Forums held in each State and Territory;
- invited submissions from organisations with an interest in mental health; and
- an open invitation to comment posted on the Auseinet website.

National consultation forums

One of the main methods of gathering feedback was via 21 Consultation Forums that took place in each State and Territory in 2004. These engaged a total of 653 participants representing a range of sectors including consumers, carers, mental health, clinical services, non-government organisations (NGOs), psycho-social support services, education, health promotion, drug and alcohol, community and academia.

People who could not attend a Consultation Forum or who wanted to provide additional comments were directed to the Auseinet website.

Invited submissions

Over 50 organisations and individuals representing peak bodies and other stakeholders for mental health were sent a written invitation to provide comment. Written or interview submissions were received from 38 of these invitees.

Auseinet website

The Auseinet website and update service was used to inform people of the *Discussion Paper* and the consultation. The *Discussion Paper* and a briefer *Summary Version* were able to be downloaded from the Auseinet website. Hard copies were also available from Auseinet. On the website an invitation to comment was placed, indicating the type of feedback specifically sought. People could email their comments through the website, or contact either Debra or Susan to directly provide comment.

3. CONSULTATION FORUMS

3.1 A capacity building approach

Face-to-face Consultation Forums in each State and Territory were used as the primary strategy for the consultation process. In order to meet the objectives of the national consultation, the development and implementation of the forums was based on a capacity building approach. Of special note, the capacity that had already been developed by Auseinet through the national consultation on Promotion, Prevention and Early Intervention for Mental Health¹ and Auseinet's subsequent work to build capacity for promotion and prevention in mental health was drawn upon².

Forums were organised by a coordinator from each of the State/Territory governments, with help in some jurisdictions from the relevant member of the Auseinet Consumer and Carer Consultative Committee or representatives of local consumer networks. Coordinators were responsible for determining the following elements of the Forums:

- *Timing* – to maximise participation (although it should be noted that there was a relatively tight time frame, with only a 3-month period available within which to schedule the consultations).
- *Location* – to facilitate participation of all stakeholders.
- *List of invitees* – each jurisdiction was responsible for determining their list of invitees to be participants in the Forums and for issuing invitations to attend. However, special attention was paid in all jurisdictions to ensuring wide consumer and carer representation, and the members of the Auseinet Consumer and Carer Consultative Committee and other consumer and carer networks were used to facilitate consumer and carer involvement.
- *Keynote speakers* – each jurisdiction organised a speaker to welcome participants to the Forum as well as a consumer and/or carer to share some of their lived experience related to preventing further episodes of mental illness. In some jurisdictions, presentations of local initiatives in relapse prevention, rehabilitation or recovery were also provided.
- *Funding* – financial support was available through Auseinet and in many jurisdictions to facilitate consumer and carer involvement.
- *Political support* – there was demonstrated commitment from government to progressing initiatives in relapse prevention for people seriously affected by mental illness.
- *Workshop* – each Consultation Forum used a workshop process to generate feedback related to the *Discussion Paper*.

¹ Parham, J & Rickwood, D (2003) *Promotion, Prevention & Early Intervention for Mental Health: National Consultation*. Adelaide: The Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet).

² see www.auseinet.com

All jurisdictions implemented Forums in late 2004, although central Australia and Tasmania also organised major Forums for the initial development of the *Discussion Paper*. Altogether, there were 21 Forums held across Australia, with a total of 653 participants. Table 1 provides a summary of the locations, dates and number of participants at each of the Consultation Forums.

Table 1. Consultation Forums		
Site	Date	Number of Participants
New South Wales		145
Campbelltown	27 October 2004	54
Parramatta	26 November 2004	52
Orange	3 December 2004	39
Victoria		120
Melbourne	17 December 2004	120
Queensland		76
Brisbane	11 November 2004	76
Western Australia		26
Perth	6 December 2004	15
Teleconference with Esperance and Kalgoorlie	6 December 2004	6
Perth community services	6 December 2004	5
South Australia		70
Adelaide	8 December 2004	53
Port Augusta	9 December 2004	10
Murray Bridge	10 December 2004	7
Tasmania		94
Hobart	14 December 2004	25
Launceston	15 December 2004	27
<i>Note: earlier Forums were held in Tasmania during development of the Discussion Paper</i>		
Hobart	16 November 2003	12
Launceston	17 November 2003	23
Burnie	18 November 2003	7
ACT		44
Canberra	15 November 2004	27
Canberra (Transcultural Mental Health)*	10 December 2004	18
Northern Territory		78
Alice Springs	29 November 2004	28
Darwin	30 November 2004	19
<i>Note: earlier consultations were held in Alice Springs, with visits also to Papunya and Kintore</i>		
	8-12 March 2004	31
TOTAL		653

*Facilitated by Stephen Druitt from Mental Health ACT

3.2 Workshops to provide feedback

Each Consultation Forum used a workshop process to generate feedback related to the *Discussion Paper*. Workshops involved the participants breaking into smaller groups to provide comments specifically on the *Discussion Paper* and the more general issue of preventing relapse for people seriously affected by mental illness.

The process used for each workshop comprised the following:

Participants broke up into smaller groups (usually about 10 people per workshop group). Where possible, groups were organised according to the different sectors represented: usually comprising a consumer group, carer group, clinical service providers group, and psycho-social services providers group. It was recognised that breaking people up into sector-related groups reduced opportunities for sharing views across sectors; however, it was argued this provided an opportunity that would yield a greater depth of information because each sector could consider the issues from its own perspective, rather than spend the group's time debating the priority and relevance of issues with other sectors. In reality, a combination of both approaches emerged, and about half the forums were sector-based groups, and about half comprised more heterogeneous groups. Importantly, in areas where there were significant numbers or representatives from Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, or other population or workforce groups, these people comprised a separate group if that was their choice.

Each workshop group was allocated a facilitator and a scribe, who were local people who had been briefed prior to the session. The following questions formed the basis for discussion:

1. What are your thoughts about the relapse prevention framework as presented in the *Discussion Paper*? Do you think it provides a good tool for developing recovery-focused services?
 - a. What do you like about it?
 - b. What don't you like about it?
 - c. Are there any gaps in the framework?
2. What other experiences have you had with relapse prevention and tools for relapse prevention? How did you find them? What difference did it make?
3. What needs to happen to ensure relapse prevention becomes standard practice in mental health services?
4. How will we know that relapse prevention has become standard practice? What sort of indicators and measures will show that we have relapse prevention as standard practice in a recovery focused mental health system?
5. Any other comments?

The facilitator led the discussion around these main points and the scribe recorded the participants' comments. A written summary of the workshops from each Consultation Forum was provided to the Forum organisers to feed back to participants. A description of the views presented by participants in the Forums is presented in Section 4.

3.3 Overview of the Consultation Forums

The following sections provide an overview of the Consultation Forums held in each of the States and Territories.

New South Wales

New South Wales was the first State to implement their consultations, with the first Forum held in Campbelltown in late October. This was the second of a series of half-day forums focussing on recovery held by the South Western Sydney Area Health Services. This Forum attracted 52 participants. Subsequently, two more Forums were held in Northern Parramatta and Orange, which attracted 54 and 39 participants, respectively. The Forum in Orange was organised specifically to engage participants from rural and regional areas.

The Forums were organised through collaboration between local Area Health Services and the NSW Centre for Mental Health. A wide range of sectors was represented at each of the Forums, with a large contingent of consumers and some carers. Importantly, transcultural mental health was represented in the NSW consultations.

Consumer and carer presentations, giving the lived experience of relapse prevention and recovery were highlighted in each the NSW Forums and these provided a rich context for discussion of the role of relapse prevention in recovery.

Key coordinator	Regina Osten, A/Senior Policy Analyst, Centre for Mental Health, NSW Health Department
Dates of forums	27 October, 26 November, 3 December 2004
Locations	Campbelltown, Parramatta, Orange
No. of participants	145
Sectors/ organisations represented	Consumers, consumer workers, carers, NGOs, transcultural mental health, general practice, mental health education, clinical service providers, Aboriginal health, child and adolescent mental health, juvenile justice, forensic mental health, mental health policy
Structure/format	<ul style="list-style-type: none"> • Half-day (Campbelltown) or full-day (Parramatta, Orange) • Opening address • Presentation by consumer or carer • Overview of <i>Discussion Paper</i> • Overview of Auseinet • Showcasing of local initiatives • Feedback discussion groups on <i>Discussion Paper</i>
Highlights	<ul style="list-style-type: none"> • Presentation by Douglas Holmes EO NSW CAG • Broad sector participation • Range of recovery focussed initiatives already underway • Local Consumer Network activities
Main issues raised	<ul style="list-style-type: none"> • Welcomed the discussion of relapse prevention – felt it was overdue • Liked the practical focus of the 4As • Liked the consumer focus and increase in a consumer driven agenda • Felt that the gaps were in implementation, resourcing and funding, particularly for step-down facilities • Argued that the capacity of case managers to effectively support relapse prevention needed to be expanded • Argued that there needed to be common goals across services and sectors • Felt there needed to be more focus on early intervention within acute services, rather the current crisis focus

Victoria

The Department of Human Services (DHS) organised a full-day Forum in Melbourne to which people from throughout the State were invited. A total of 120 people attended the Forum, comprising consumers, carers, psychiatric disability rehabilitation services (PDRS), clinical services and the DHS.

An important aspect of the Victorian consultation was the input of the PDRS sector. This group argued that their sector's work was not well recognised in the *Discussion Paper*, but noted that Victoria was the only jurisdiction with such a well-developed psychiatric disability sector and that this greatly enhanced its capacity in the area of relapse prevention. For the PDRS, relapse prevention was a routine part of everyday practice.

Key coordinator	Bernadette Pound, Mental Health Branch, Department of Human Services
Date of forum	17 December 2004
Location	Melbourne
No. of participants	120
Sectors/ organisations represented	Consumers, carers, psychiatric disability support sector, clinical services, psychiatric research, Department of Human Services
Structure/format	<ul style="list-style-type: none"> • Full-day • Opening address • Presentations by consumers and carers • Overview of <i>Discussion Paper</i> • Overview of Auseinet • Small group discussion of <i>Discussion Paper</i>
Highlights	<ul style="list-style-type: none"> • Presentations by consumers and carers • Representation from Psychiatric Disability Rehabilitation sector
Main issues raised	<ul style="list-style-type: none"> • Concern of lack of representation of PDRS in the <i>Discussion Paper</i> and argument that relapse prevention is nothing new to this sector • Argued that the 4As needed to be made practical and relevant to consumers, carers and clinicians • Felt there needed to be a more strengths-based approach • There needed to be better recognition and integration of the work of the psychiatric disability support sector by acute and clinical services

Queensland

Queensland used the opportunity provided by an already arranged meeting of managers and directors in mental health to incorporate feedback on the *Discussion Paper*. This provided an opportunity to gain input from 75 clinicians and program managers. Unfortunately, an additional Forum advertised for consumers was not well-attended. However, input from consumers was organised separately at a later date by one of the consumer consultants, and a written summary of their views was provided.

Key coordinators	Ivan Frkovic & Elizabeth Davis, Mental Health Unit, Queensland Health
Date of forum	11 November 2004
Location	Brisbane
No. of participants	76
Sectors/ organisations represented	Mental health, nursing, additional input from consumer network
Structure/format	<ul style="list-style-type: none"> • Brief introduction to <i>Discussion Paper</i> • Small-group discussion on <i>Discussion Paper</i> • Consumers undertook a separate consultation process independently and provided a written submission
Highlights	<ul style="list-style-type: none"> • Major input from clinicians and mental health services directors • Direction to Fraser Coast Early Intervention Service Reorientation Project
Main issues raised	<ul style="list-style-type: none"> • 4As provides a useful set of principles, comprehensive • Recognises what is already done and is based on good case management - don't need to reinvent the wheel • Relapse prevention is taking place in most areas, but is not formalised and there is no access to the full range of components to implement • Likely to provide the outcomes if have the resources to implement

Western Australia

The Forum in Western Australia was small because there were other current issues that were a focus for consumers, carers and services providers at the time. Nevertheless, the Forum was attended by people with diverse experiences of continuing care for mental illness. Some people had experienced comprehensive continuing care, while others had experienced fragmented support and not had all their needs met in a timely manner.

The videoconference organised with rural and remote service providers was a highlight and showed how technology can be used to connect with people in remote regions. While these remote areas had significant challenges for continuing care and relapse prevention, it was evident that remote service providers were able to better integrate clinical and non-clinical services through partnerships, greater flexibility and innovative approaches to problem-solving.

A visit to Ruah Community Services provided an opportunity to see how a peer-led approach to relapse prevention and recovery was being implemented through training and support in the *Wellness Action Recovery Plan*. This was shown to be a very effective model to support the recovery of people who had been seriously affected by mental illness, and one which has a major focus on relapse prevention but placed within a wellness framework.

Key coordinators	Vicki Caudwell & Kylie Wake, WA Department of Health
Date of forum	6 December 2004
Locations	Perth, Videoconference with Esperance and Kalgoorlie, Visit to Ruah Community Services
No. of participants	26
Sectors/ organisations represented	Consumers, carers, NGOs, recovery-focussed services, rural health services, Aboriginal and Torres Strait Islander health services
Structure/format	<ul style="list-style-type: none"> • Visit to community mental health services • Half-day Forum with opening address, consumer presentation, Overview of <i>Discussion Paper</i>, Overview of Auseinet, discussion group on <i>Discussion Paper</i> • Videoconference discussion on <i>Discussion Paper</i> with Esperance and Kalgoorlie
Highlights	<ul style="list-style-type: none"> • Discussion with remote area service providers • Innovative and flexible approaches using the services and supports available to provide continuing care in remote areas • Presentation of implementation of <i>Wellness Action Recovery Plan</i> in Ruah Community Services
Main issues raised	<ul style="list-style-type: none"> • Problems with lack of financial support for consumer networks • Need for more widespread support and resourcing of community support and rehabilitation services • Issues of distance needed to be innovatively dealt with • Major focus needs to be on the needs of Aboriginal peoples

South Australia

A comprehensive consultation was organised in both metro and country areas in South Australia with 70 participants involved overall. The metro consultation was noted for the broad sector representation and was an opportunity to highlight working examples of rehabilitation and relapse prevention taking place in the community. The country Forums gave an in-depth view of the issues in two local country areas—areas experiencing multiple social and economic disadvantages, which is increasingly common in rural Australia. These areas also have less access to support services for mental health and struggle to sustain more than a basic crisis approach.

Key coordinator	Adrian Booth, Mandy McCulloch, Suzanne Heath, Department of Human Services
Dates of forums	8, 9, 10 December 2004
Locations	Adelaide, Port Augusta, Murray Bridge
No. of participants	70
Sectors/ organisations represented	Consumers (including young consumers), carers, rehabilitation services, NGOs, community health, clinical services, hospital services, adolescent services, drug and alcohol services, corrections, migrant health, health promotion, education, Aboriginal health, suicide prevention
Structure/format	<ul style="list-style-type: none"> • Full-day in Adelaide, half-days in country areas • Opening address • Consumer and carer stories • Examples of current initiatives in relapse prevention • Overview of <i>Discussion Paper</i> • Overview of Auseinet • Small group discussions on <i>Discussion Paper</i> • Country areas did not have opening presentations
Highlights	<ul style="list-style-type: none"> • Broad sector involvement and participation • Urban and rural contrasts
Issues raised	<ul style="list-style-type: none"> • Need for key logistic steps to get from concepts to practice • Domination of crisis response • Ad hoc work in relapse prevention and recovery, but not routine or supported by management practices from the acute sector • Excellent models from rehabilitation and NGO sector, but not widely available • Need for wider range of treatment options and support for self-management • Need to listen to carers • Lack of consumer networks in country areas • Increasing and multiple disadvantages in country areas

Tasmania

Tasmania held two rounds of consultation, in late 2003 during development of the *Discussion Paper* and again in late 2004 to consider the issues raised in the *Discussion Paper*. At the same time, a review of rehabilitation services took place in Tasmania, which involved an extensive mapping and consultation process. This gave Tasmanians a sense of optimism with hope for improved services for continuing care for people who had been seriously affected by mental illness.

The areas of Hobart, Launceston and Burnie were covered in the consultations with 94 participants overall. Services to support relapse prevention in Tasmania suffer from having a very small population spread over a large and mostly rural area. The population cannot support the wide range of services that need to be available. During the consultations, participants realised that a great deal was to be gained by working together and improving their networks, which could help to compensate for the lack of support services.

Key coordinator	Wendy Wolf, Mental Health Services
Dates of forum	16-18 November 2003, 14-15 December 2004
Locations	Hobart, Launceston, Burnie
No. of participants	94
Sectors/ organisations represented	Consumers, carers, mental health, community health, transcultural mental health, NGOs, hospital services, alcohol and drug services, CRS, Aboriginal health, occupational therapy
Structure/format	<ul style="list-style-type: none"> • Half-day forum • Overview of <i>Discussion Paper</i> • Overview of Auseinet • Small group discussion on <i>Discussion Paper</i> • Carer stories
Highlights	<ul style="list-style-type: none"> • Broad range of sectors participating • Networking between participants
Issues raised	<ul style="list-style-type: none"> • Major problems for Tasmania with small population living mostly in rural areas • Lack of rehabilitation and accommodation services • Need for better integration between hospital services and community services, particularly through better discharge planning • Lack of services for young people • Significant transcultural mental health issues, with small support base from communities

Australian Capital Territory

The ACT undertook two consultations, one general consultation and one specifically for people involved in transcultural mental health. Transcultural mental health issues are currently a focus of several consumer and carer organisations in the ACT. The transcultural consultation was facilitated by Stephen Druitt, as Debra and Susan were involved in a consultation in South Australia.

The general Forum was well-attended from a broad range of sectors. It was evident that improvements have been achieved for ACT mental health services with the trialling of Collaborative Therapy in adult mental health services. This has improved service coordination and support over time for many consumers, and encouraged better integration between services and sectors, as well as highlighted the importance of prioritising and supporting consumer participation in their own treatment planning.

Key coordinator	Stephen Druitt, Mental Health ACT
Dates of forum	15 November, 10 December 2004
Location	Canberra
No. of participants	44
Sectors/ organisations represented	Consumers, carers, transcultural mental health, adult mental health, child and adolescent mental health, mental health policy, primary care, Aboriginal health, alcohol and drug services
Structure/format	<ul style="list-style-type: none"> • Half-day workshop • Welcome - ACT Mental Health • Overview of <i>Discussion Paper</i> • Overview of Auseinet • Small group discussion of <i>Discussion Paper</i>
Highlights	<ul style="list-style-type: none"> • Opportunity to network • Growing collaboration evident among ACT services • Strong consumer networks
Issues raised	<ul style="list-style-type: none"> • Collaborative Therapy being successfully trialled in ACT • Relapse prevention as presented in <i>Discussion Paper</i> fit well with current directions trying to be achieved in ACT • 4As Framework was useful • Consumer focus was welcomed • Need for increased resourcing for transcultural mental health before the 4As Framework could be implemented • Need for resources – education and training, staffing, alternatives

Northern Territory

The Northern Territory held two rounds of consultations: in early 2004 as part of the development of the initial *Discussion Paper*, and late 2004 to consult on the paper. In the first consultation, issues for central Australia were emphasised with a range of consultations taking place in Alice Springs and visits to remote communities to give special attention to the needs of Aboriginal peoples in remote areas.

Altogether, 78 people were engaged in the Northern Territory consultations and there was representation from a very wide range of sectors, including corrections and crisis accommodation services. Clearly evident was the essential need for effective collaboration between different services and sectors in order to meet the significant challenges for the Northern Territory as a result of its small but very diverse and widespread population.

Key coordinator	Cheryl Furner, Sarah O'Regan, Nicholas Stiles, Department of Health and Community Services
Dates of forums	8-12 March, 29-30 November 2004
Locations	Alice Springs, Darwin
No. of participants	78
Sectors/ organisations represented	Consumers, carers, Aboriginal health workers, mental health NGOs, drug and alcohol services, correctional services, health services, general practice, accommodation services, Lifeline
Structure/format	<ul style="list-style-type: none"> • Welcome – NT Health • Overview of <i>Discussion Paper</i> • Overview of Auseinet • Small group discussion of <i>Discussion Paper</i> • Consumer and carer stories
Highlights	<ul style="list-style-type: none"> • Broad representation of a range of sectors • Consumer support initiatives in central Australia • Awareness of issues for remote Aboriginal communities
Issues raised	<ul style="list-style-type: none"> • 4As Framework is empowering for consumers • Mental health services are reactive not active • Need to focus on de-stigmatisation • Need for community development to provide support for approaches to relapse prevention for Aboriginal peoples in remote communities • Serious workforce shortages • Significance of suicide in Aboriginal communities

4. SUMMARY OF COMMENTS

The following section gives a summary of the main issues raised in the workshops from the Consultation Forums and through the other consultation processes. For the most part, similar issues were raised in all the Consultation Forums across the country, so comments are aggregated and not specified according to State/Territory. Diverging comments between States/Territories tended to reflect jurisdictional differences in the level and types of mental health services available in the jurisdiction. For example, the Psychiatric Disability Rehabilitation Sector (PDRS) is much stronger in Victoria than elsewhere; consequently, comments from and related to this sector were generally restricted to Victoria. Mostly, however, similar themes were evident across Australia.

4.1 Comments on the relapse prevention framework presented in the Discussion Paper

Overall, there was a very positive response to the *Discussion Paper*. Respondents were pleased that this issue was finally receiving long-needed attention. Moreover, respondents appreciated that the *Discussion Paper* was grounded in lived experience and had prioritised consumer voices. People particularly liked the use of consumer (and other) statements throughout the *Discussion Paper*, which they felt grounded the paper within lived experience and gave it an appropriate balance between the lived experience and academic research.

Many consumers and carers commented on the positive and optimistic approach taken by the *Discussion Paper*, which they felt was empowering and affirming. They appreciated that prevention was placed within a recovery focus and viewed as an ongoing learning process whereby people needed to be supported to learn over time what works best for them. It was felt that the *Discussion Paper* contributed to a hopeful and proactive approach for people with mental illness.

Many consumers confirmed the issue raised in the *Discussion Paper* that they didn't like the terms "relapse" and "relapse prevention". However, it was difficult for people to agree on a preferred term, as people used diverse language to refer to their ongoing mental health status. The terms "episode" and being "well" versus "unwell" tended to be preferred to relapse. While consumer respondents generally preferred a stronger wellness focus, they did agree that the illness and prevention focus of the *Discussion Paper* was a useful and practical step forward in the area of continuing care. Most people agreed that prevention was an essential component of recovery, even though it was more illness focused. Interestingly, there was a significant number of consumers who also objected to the term "recovery", arguing that it was a misuse of the word to apply it in the context of mental illness and that it set up unrealistic expectations of "full recovery" for many people.

Respondents universally endorsed the 4As Framework. Consumers, carers and service providers all agreed that the Framework was practical, holistic and captured all the elements needed that impacted on relapse. The broader focus on the factors affecting mental health, such as living situation, physical health and the need for meaningful involvement, was strongly endorsed. People felt that having a wider range and choice of service options, which could be matched to people's unique needs and preferences, was essential to future wellbeing.

Most service providers stated that the 4As Frameworks provided a comprehensive and useful set of principles, which were practical and able to be translated into practice in different service contexts. Importantly, the Framework validated the way some people and sectors already operated, particularly those providing psycho-social and rehabilitation services. While the Framework did not provide any real innovations in approach, its value was that it brought together an approach that advocated an holistic approach to mental health and wellbeing. Many commented that it was timely that the broader promotion, prevention and early intervention (PPEI) focus was brought to the continuing care end of the mental health intervention spectrum. This shifted the focus from a medical model to a model that emphasised risk and protective factors, and that supported a more active role for consumers and their families and carers.

As the Framework was seen to be validating of the way that many services were already operating, it was argued that there needed to be greater acknowledgement of those services and sectors that were already implementing this approach. For example, the PDRS in Victoria has effectively used this approach for many years. This sector is not widespread elsewhere, however, and it was agreed that the mental health system, overall, did not support full implementation of the Framework and there were service gaps in all areas. While the emphasis on the role of general practice was commended, it was argued that greater consideration of the broader community sector was warranted.

Some gaps were noted in the content of the *Discussion Paper*. During the consultations it became evident that there needed to be more consideration of the unique issues for: parents with mental health problems and their children; people with complex problems, especially those with co-occurring drug and alcohol problems; forensic clients; people with suicidal ideation; and people from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds. It was noted, however, that these were areas of developing understanding and that there was not a lot of easily available material to draw upon; greater emphasis, therefore, needed to be placed on developing better understanding in these areas. While some people felt the sections on Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds needed further elaboration, others maintained that the paper acknowledged cultural differences in presentation of relapse and had a good focus on Indigenous mental health.

It was felt that there could be greater emphasis on carers, including children as carers. Some respondents argued that throughout the *Discussion Paper* there was an assumption that carers were well and capable of fulfilling the substantial role that was assigned them; yet, there were many reasons whereby the carers' role was made more difficult that had not been adequately covered.

With the exception of the terms "relapse" and "relapse prevention", most of the terminology used in the *Discussion Paper* was validated. In particular, respondents stated that it was very useful to have the terms "recovery", "rehabilitation" and "relapse prevention" clearly described and their differences made clear. However, the term "case management" received some criticism, and some people preferred the term "key worker".

It was clear to respondents that the *Discussion Paper* was only a first step toward progress in this area and that there needed to be much more in the way of resources to support implementation. For example, it was suggested that there needed to be concrete examples of the 4As Framework as well as examples of action plans that were being used in different services and local areas. The *Discussion Paper* was far too long to be accessible to most people, and needed to be translated for different audiences. This was seen to be a particular

challenge for some community groups, such as remote Aboriginal and Torres Strait Islander communities, although programs such as AimHi were already developing resources in this area.

4.2 Other experiences of relapse prevention

Overwhelmingly, the type of support put forward as providing the best experience of relapse prevention was peer support for consumers. Being involved in consumer-related and run activities was commonly cited as an essential component of maintaining ongoing wellbeing. Peer support was generally provided through non-government organisations and often focused on social or vocational programs, education and advocacy. It was through this type of support that people gained social interaction and companionship, acceptance and relief from stigma, meaningful activity, and most importantly, hope. Opportunities to be involved, even through volunteer work, were cited as very effective in supporting wellbeing. Many consumers argued that they needed meaningful activity, connectedness, and structure to their day to stay well. However, this type of support was not widely available outside major metropolitan areas, and consumers in rural and remote areas were particularly poorly served.

Peer education was also one of the main ways that people learned to recognise early warning signs and to understand the risk and protective factors for their mental health. The Wellness Recovery Action Plan (WRAP) by Mary Ellen Copeland was a peer-based initiative that was especially useful helping consumers understand the factors that affected their ongoing wellbeing and ways to manage their mental health. Tools, such as self-rating scales to encourage self-monitoring of symptoms and wellbeing, were effectively used by many consumers, and some family and carers, to support wellbeing. Many of these tools were developed by consumers for consumers. However, tools developed by the Commonwealth Rehabilitation Service to help support people to stay well and get back to work were also valued.

Approaches such as Collaborative Therapy, and other programs that were attempting to develop partnership models and enhance self-management for consumers, were praised in the few areas where they were available. Many local areas and jurisdictions are developing partnership models, and where these are able to be developed and effectively implemented they are very effective. However, there are many obstacles to developing effective partnerships that require perseverance to overcome.

Many services had examples of self-management, discharge and care plans that were being effectively used. However, these appear to be available on an ad-hoc or informal basis and are not a routine component of the mental health system. Furthermore, even when a service implemented such planning, there was rarely the whole system support within the community to effectively support the plan. Nevertheless, many consumers and service providers had experience of useful prevention and recovery planning. Advanced Directives, as a way to plan for preferred options if the consumer becomes acutely unwell, were highly valued by consumers in areas where their implementation was supported.

It was noted that plans needed to be holistic and include a whole of life focus, as recognised by the 4As Framework. This needed to include accommodation and physical (including dental) health. A few programs and planning approaches had a specific focus on physical health, which consumers and carers found to be very important for supporting ongoing wellbeing and improved mental health.

Healthy lifestyle programs more broadly, including stop-smoking programs for people with mental illness, were reported found to be helpful. A focus on physical wellbeing, and its impact

on mental health, was essential. Physical activity, even simply walking or gardening, was used by many consumers to maintain their wellbeing. However, for consumers who were isolated or lacking in motivation, recreation link officers had been used in some areas to successfully help people to get involved in physical activity and other recreation activities that helped prevent future illness.

Many services and service providers used prevention models that they found effective. Stress-vulnerability models, stages of change approaches, and other holistic models that considered the dynamic nature of the risk and protective factors that affected people's mental health were incorporated into many approaches. These types of models were put into practice by case managers and support workers, PDRS, community service providers, and allied health professionals such as psychologists and counsellors.

Many consumers, as well as service providers, reported the effectiveness of Cognitive Behaviour Therapy, mindfulness therapies, Yoga and other forms of meditation and relaxation as fundamental to their ongoing wellbeing. There were numerous stories that while medication had been essential for a person to stabilise their mental health, ongoing wellbeing was achieved through these cognitive techniques.

Carers noted that ASSIST training and Mental Health First Aid were programs that were very useful for them, providing them with skills to help support the consumer, as well as knowledge that reduced the stress they experienced.

The Children of Parents with Mental Illness (COPMI) program was repeatedly mentioned as an essential and greatly valued support for this population group, who had significant needs.

Finally, while many and varied examples of ways to prevent relapse and support wellbeing were provided by respondents, it was evident that these were available only on an ad hoc basis. They had often been developed either informally or on a limited service basis, and very often consumers and their families and carers only came across them by luck, accident, or persistence. There was no routine approach to incorporating ongoing prevention within the mental health system in any jurisdiction. Consumers, and their families and carers, could have no expectation of receiving an holistic, ongoing and planned approach to continuing care. Importantly, service providers, particularly psychosocial service providers, had no expectation of being part of an integrated and holistic system of mental health care.

4.3 Implementation

Overwhelmingly, many of the feedback comments related to implementation issues. While respondents strongly supported the 4As Framework, they did not believe that the resources and system supports necessary to effectively implement and sustain such an approach were in place. Moreover, respondents were doubtful that more resources would be forthcoming, and that this approach could not be achieved without a significant injection of money and additional support. Many people voiced the view that, like so much other Australian mental health policy, yet again we had produced excellent rhetoric that was not implemented in practice.

Key implementation issues were:

- resources;
- translating policy into practice;
- reorientation;
- attitudes, education and training; and

- applications for people with complex conditions and comorbidities, Aboriginal and Torres Strait Islander peoples, and people from culturally and linguistically diverse backgrounds.

Resources

It was strongly felt that the resources to implement the 4As Framework were not available. In particular, there needed to be much improved resourcing of the peer support sector. While this sector was developing and had become very strong in some areas, there needed to be support for the sector to grow and to reach areas where it was currently not available, such as rural and remote areas.

Similarly, the carer support sector needed to be better resourced. This sector was much less well developed than the consumer support sector, but equally important for families and carers, and needed to have additional resources to enable it to significantly expand. Other supports for carers also needed to be resourced; such as more flexible working arrangements that enabled time off when their family member was unwell.

Jurisdictions and local areas needed to be enabled to map their resource needs as a first step toward determining the gaps in service provision. Few areas had the data and information required to determine exactly what level and type of services were required for the population needs of the local area. To support a population health approach, there needed to be information and guidelines available to determine the actual resource needs of a local area.

While the acute care sector was overstretched in many areas, resources for the non-government organisation and psychosocial disability sectors, in particular, needed to be significantly improved. With the exception of Victoria, the PDRS sector is significantly under-resourced, but essential to implementing the 4As Framework.

A wider range of accommodation and treatment options was also imperative. This needed to include respite care, step-up/step-down services, and sub-acute models of care and support. Service options needed to be available to bridge the 'all or nothing' focus of acute care.

Services specific to the needs of particular population groups required resourcing; these were rarely available outside the major metropolitan areas. This included younger people and older people with mental health problems, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, and people with complex conditions including people who had been forensic patients and those who had co-occurring drug and alcohol problems.

Importantly, the resources that *were* available in a local area needed to be better understood and more accessible. Up-to-date lists of the options for self-help, peer support and mental health and allied health services needed to be available in all local areas.

Another area where lack of resources significantly impacted was the lack of research funds. This meant that many alternatives to the medical model did not have an evidence base. This did not mean that the alternative was not effective, but rather that no research had been carried out to determine its effectiveness. While the evidence base for CBT was expanding, partly because it was the focus of much of the research effort, there was a paucity of research devoted to other types of therapies and supports. Furthermore, some types of health promotion and community-based supports were not amenable to being researched through the 'gold standard' of a randomised controlled trial, and a wider range of research evidence needed to be valued. More treatment and support options needed to be available for clinicians, community support workers,

and consumers and their families and carers. This required greater research support and effort, and dissemination of the evidence base for effective alternatives.

Translating policy into practice

A common criticism of the *Discussion Paper* was that it did not give any guidance regarding implementation: either how to go about implementing the 4As Framework or who was responsible for making it happen.

Regarding making it happen, most respondents felt that the Federal government needed to take a more active role in terms of leadership, particularly around ensuring accountability. It was felt that implementation should not be left to the States/Territories. Jurisdictions, local areas and the managers of mental health services needed to be mandated to put into place the supports to enable the 4As Framework to be implemented. For example, it was suggested that national accreditation systems, such as the National Standards for Mental Health Services, be used to support the Framework, and regular audits be carried out to ensure effective implementation.

A significant amount of system development needed to take place before the 4As Framework could be effectively adopted. This included the development of Information Technology systems that could support information sharing, integrated service approaches and longer-term planning. There were many innovations in this area, particularly supporting general practice, but the further and accelerated development of these system supports needed to be prioritised. In parallel, guidelines to ensure privacy and confidentiality, while information was effectively shared, needed to be strengthened.

It was acknowledged that significant progress was occurring in the area of preventing and managing chronic illness, particularly around the development of primary health care networks. Stronger links should be forged with this area as there were many commonalities. For example, the role of community pharmacy was not strong in the mental health field, but was increasingly being acknowledged as part of primary health care.

Essential to implementing the 4As Framework were a range of other supports that could turn the rhetoric into reality. Suggested additional resources included:

- summaries of the Framework that were in formats that were appropriate for different population groups, such as young people and Aboriginal and Torres Strait Islander peoples;
- examples of good practice for example in discharge plans, identification of early warning signs;
- templates and guides for implementation at local levels;
- development of standard tools; and
- ways to share experiences and information.

Reorientation

The need for reorientation of the mental health system has been argued since the advent of the National Mental Health Strategy, and considerable progress has been achieved. However, implementation of the 4As Framework requires even greater effort in this direction.

Respondents acknowledged that the mental health sector needed to change its acute focus to become more holistic, proactive, integrated with primary health care, and long-term. It was argued that reorientation needed to occur at all levels, including: recruitment, orientation, supervision, and professional development for staff; and for all types of health and community

services. Some respondents argued that the focus of the entire mental health system needed to be reversed: currently the model was of acute clinical services supported (where available) by community support and psychiatric disability services; instead the model should be community and disability services supported by acute and clinical care.

The need for flexibility and the ability to work in an integrated and holistic way were emphasised. In current mental health services, too often exclusion criteria were used that meant that many people fell through the cracks. This applied particularly to people with drug and alcohol problems, physical or mental disabilities, and other conditions that made their situation more complex. Part of this was attributed to the specialist nature of mental health care; many professionals wanted to be specialists in their particular area and guard their expertise, rather than work with a more holistic and integrated approach. This was especially evident between specialist mental health and drug and alcohol services; where people with co-occurring problems were either rejected by both or batted back and forth between the specialist services.

Furthermore, it was argued that many mental health services spent more time assessing suitability to be in a program than they did on longer-term planning. Lack of forward planning was a common complaint; many services had no planning mechanisms, and even when they were available, they were often not implemented. It was argued that policy and procedure manuals should prioritise self-management and recovery planning. For example, on readmission to an acute service the previous discharge plan should be automatically reviewed to determine what worked and what didn't and what needed to be changed in planning for the next discharge.

Intersectoral cooperation was thought to be the foundation of reorientation, and this required formal mechanisms to be in place. At present, where reorientation was occurring, it was generally being achieved through informal arrangements, which then broke down if any of the people who had put them together left the organisation. Services with more formal arrangements, such as discharge plans, often had problems ensuring that they were taken up and implemented outside their own service. It was noted that one area that was rarely considered was the integration of private practice with publicly provided services.

Concerns were also raised about the privacy issues that arose with more integrated service arrangements. Effective partnerships were predicated on sharing information between services, and also with consumers and possibly family and carers. While there was an urgent need for more communication, there were sensitive issues to be resolved in this area and a great deal more needed to be done to develop protocols for sharing information while protecting privacy. For example, several carers noted that there needed to be triggers negotiated for when carers needed to be notified, such as when consumers were discharged from hospital.

On the other hand, the risk averse culture of mental health also needed to change. Services and service providers needed to be supported to be more flexible and proactive so they could effectively meet the changing needs of consumers and their families and carers.

Attitudes, education and training

Attitude change was argued to be fundamental to reorientation and supporting implementation of the 4As Framework. The elimination of stigma and improved attitudes were required in many areas, including the media and general public, but was a particular problem in mental health services themselves. It was argued that mental health services and service providers that did not believe in recovery could not effectively implement the Framework.

While attitudes in mental health services were improving in many areas, there was still considerable room for improvement. It was suggested that the curricula of all the professions involved in the delivery of mental health services be examined to ensure that they promoted a holistic, preventive approach. Cross-sector training was argued to be an effective way of helping to change attitudes and encourage new practices, particularly training that involved both clinical and psychosocial service providers, and where consumers and carers were involved in delivering the training. In particular, the value of the role and experience of non-government organisations and the psychiatric disability sector needed to be emphasised; rotating staff through different types of services, such as hospital and community services, was put forward as a way of encouraging better collaboration.

Stigma was particularly strong in some culturally and linguistically diverse communities, particularly for older generations and people who had experienced torture and trauma. This discouraged the early use of services needed for preventive approaches. It was suggested that younger people from culturally and linguistically diverse communities should be targeted to change their attitudes and to then act as agents of change throughout their communities.

Applicability for diverse population groups

There was some concern that the Framework was developed within a mainstream context and that there needed to be greater understanding before it could be applied to other population groups. The *Discussion Paper*, itself, argues that prevention within the context of Aboriginal and Torres Strait Islander communities is poorly understood.

The understanding of cultural differences in mental health is a developing area that requires more research and funding. For example, families were argued to be especially important for culturally and linguistically diverse communities, and the different roles of families and how to better integrate them within the mental health system needed to be a focus of investigation. Better understanding of recovery and the different factors that support mental health and wellbeing in diverse cultures needed to be explored.

As mentioned earlier, additional resources needed to be provided to translate the 4As Framework into format that were appropriate and applicable to the diverse range of population groups that made up Australian society.

4.4 How will we know that relapse prevention has become standard practice?

Respondents were asked to consider how we would know whether the 4As Framework had been implemented and become standard practice. Respondents came up with a wide range of outcome and process indicators, which included the following:

- Decrease in readmission rates
- All consumers will have a care plan that has been negotiated with them
- Increased consumer satisfaction with mental health services
- More client control of mental health services
- Consumer roles, such as consumer consultants, will be a regular part of the mental health system
- Greater participation of consumers in community activities, work and social activities. In particular, greater participation of consumers in paid employment.
- Improvements in outcome measures like HoNOS
- Decreased suicides

- Reduced homelessness
- Improved physical health, including dental care, for consumers
- Broader scope of services will be available and consumers will be empowered to try different approaches and have a wider range of options to try
- Increased carer satisfaction with mental health services
- Decreased stress for carers
- Greater service access for people from culturally and linguistically diverse backgrounds
- Earlier service use
- Increased funding to NGO sector, including funding for training
- Substance use will be incorporated and addressed
- Evidence of collaborative partnerships
- More cost-effective services
- Less staff turnover in mental health services, and more satisfied staff
- Decreased workloads for mental health workers
- Key Performance Indicators (KPIs) for mental health services will include measures of return to hospital, such as length of time between admissions and admissions within 28 days.
- Reduced stigma
- Decreased activity of Mental Health Tribunal
- Less adverse publicity
- Decrease in coercive services and CTOs
- Less police involvement with mental health clients

5. FUTURE DIRECTIONS

The *Discussion Paper* was almost universally agreed to be an important first step to place prevention within the context of continuing care on the mental health agenda; something that was long overdue. Through the national consultation, it had achieved its aim of stimulating debate in this area across Australia. However, while it provided a platform for discussion, this alone could not achieve change in practice nor progress toward implementation.

A range of actions needed to take place to progress the ideas endorsed from the *Discussion Paper*:

Firstly, it was evident that the 4As Framework for preventing further episodes of mental illness needed to be more succinctly described in a shorter document that was more accessible than the lengthy *Discussion Paper*.

Secondly, and most importantly, it was argued that a range of education and training resources and tools needed to be developed to help jurisdictions, and local areas and services, implement the Framework. There needed to be easily accessible information on what was currently happening across Australian and internationally, and examples of best practice in relapse prevention interventions and programs. The Auseinet website was seen as an effective vehicle for disseminating this information for many people. However, it was noted that not everyone had easy access to the web and that there needed to be hard copy alternatives also available.

Most important for implementation was availability of practical information around key implementation strategies. This included guidance on how to form and sustain partnerships between services and across sectors, such as development of MOUs and discharge planning processes; how to manage change within an organisation of service to fully operate with a recovery orientation; and how to support staff to reorient from current practices (particularly within currently available resources).

Thirdly, it was felt that the *Discussion Paper* should be slightly revised to reflect some of the concerns raised through the consultation, particularly relating to gaps in content, and then be made widely available.

Lastly, it was unequivocally agreed that additional resources were urgently needed by the mental health sector (including community care and primary health care) to progress the National Mental Health Strategy, with the 4As Framework for prevention of further episodes of mental illness a strong focus.

Appendix 1. Letter of invitation to comment sent to peak organisations and other stakeholders

Invitation to comment on the *Discussion Paper* *Pathways of Recovery: Preventing Relapse*

Dear

This letter is to invite your organisation to comment on the *Discussion Paper, Pathways of Recovery: Preventing Relapse*. This *Discussion Paper* has been developed by the Mental Health Promotion and Prevention Working Party (PPWP), in response to concerns by consumers and others regarding the role of relapse prevention in the recovery process for people seriously affected by mental illness. The *Discussion Paper* aims to encourage discussion of issues related to relapse prevention and consideration of ways to ensure that relapse prevention is a routine part of continuing care within Australia's mental health care system.

The *Discussion Paper* has been produced in two versions: a full copy and a shorter summary version. Copies of each version are enclosed with this letter. They are also available electronically at auseinet@flinders.edu.au and further hard copies can be ordered through Auseinet: Tel: 08 8201 7670.

PPWP wishes for all stakeholders to be given an opportunity to comment on the *Discussion Paper* and to provide input on ways that can help ensure that relapse prevention becomes a routine part of continuing care. To enable this, your organisation is invited to comment. Your views including, but not restricted to, the following areas would be appreciated:

- Comments on the issues raised and the approach taken in the *Discussion Paper*.
- Other issues or approaches that need to be considered.
- Views on what is required to ensure that relapse prevention becomes a routine component of continuing mental health care and self-care.
- Comments on what is needed to support people and services to put this approach to relapse prevention into practice.

Your organisation can provide feedback in the following ways:

- 1) You are welcome to provide feedback directly to:
Debra Rickwood (Project Consultant) via email: debra.rickwood@canberra.edu.au
or **Susan Mitchell** at Auseinet: tel 08 8201 7670
email: susan.mitchell@flinders.edu.au
- 2) Face-to-face consultations will be held during October, November and December 2004 in each State and Territory. Please contact your State/Territory mental health branch of government for further information about the consultations in your area.

The Mental Health Promotion and Prevention Working Party welcomes your input and is looking forward to receiving your comments. Please note that the final date for submission of comments is **20th December 2004**.

Appendix 2. Questions for invitation to comment via Auseinet website

Discussion Paper on the role of relapse prevention in the recovery process for people seriously affected by mental illness

NATIONAL CONSULTATION FEEDBACK

Please provide feedback around the following questions:

1. What are your thoughts about the relapse prevention framework as presented in the *Discussion Paper*? Do you think it provides a good tool for developing recovery-focused services?
 - a. What do you like about it?
 - b. What don't you like about it?
 - c. Are there any gaps in the framework?
 2. What other experiences have you had with relapse prevention and tools for relapse prevention? How did you find them? What difference did it make?
 3. What needs to happen to ensure relapse prevention becomes standard practice in mental health services?
 4. How will we know that relapse prevention has become standard practice? What sort of indicators and measures will show that we have relapse prevention as standard practice in a recovery focused mental health system?
 6. Any other comments?
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Thank you 😊

Debra Rickwood Debra.Rickwood@canberra.edu.au
Susan Mitchell Susan.Mitchell@flinders.edu.au