MENTAL HEALTH AUSTRALIA & NATIONAL MENTAL HEALTH CONSUMER & CARER FORUM

Advice to governments: evidence-informed and good practice psychosocial services

Psychosocial Services to fund outside the National Disability Insurance Scheme

January 2024

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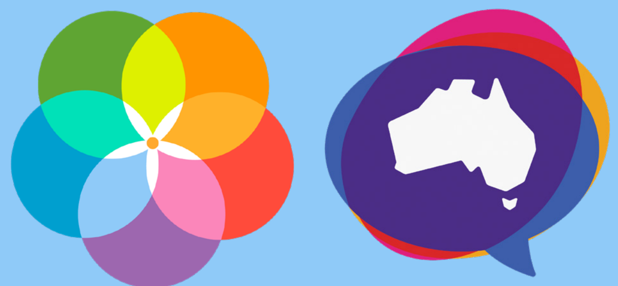

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Foreword

Despite significant mental health reforms in recent decades, Australia has yet to establish a comprehensive range of community-based mental health supports that can help people with lived experience of mental ill-health to thrive in the community.

People with lived experience of mental ill-health, carers, family and kin have consistently called for urgent system transformation. The World Health Organisation and United Nations are now supporting this call, highlighting not only human rights violations and coercive practices tragically experienced in mental health systems, but the need to move towards more holistic ways of understanding and responding to psychological distress and mental ill-health.

Investing in community-based psychosocial supports is a promising way to reform and innovate Australia's mental health system. This can help ensure that all Australians have access to affordable and effective care when and where they need it.

This advice to governments outlines psychosocial service principles, models and discrete services that should inform Australian governments' thinking on investment in psychosocial services outside the National Disability Insurance Scheme. It shows governments can confidently invest in a broad and rich variety of psychosocial services, underpinned by sector supported principles, knowing these services will achieve good outcomes for people with

lived experience of mental ill-health, carers, family and kin. Such investment represents a fundamental piece of the larger puzzle of establishing a robust community mental health system.

Through decades of advocacy, we have learned that it is essential to frame our needs in our own terms, based around human rights and what supports people to thrive. This paper is not just a list of evidence-informed and good practice psychosocial services. It is also a call for a shift in perspective and focus, where the main priority is to uphold the human rights of people experiencing mental health challenges and provide a holistic approach that responds to psychological distress and mental ill-health inclusive of carers, family and kin.

An individualised, medical approach to psychological distress and mental health challenges is inherently limited. Furthermore, according to the World Health Organisation and the Office of the High Commissioner for Human Rights "a growing body of evidence sets out how coercive practices negatively impact physical and mental health, often compounding a person's existing condition while alienating them from their support systems."[1]

Although most legislation authorising coercive practices in public mental health systems refers to their use as least restrictive and last resort, there has been a lack of other supports and other less restrictive alternatives, which highlights the need for different approaches.

A rights-based perspective invites an approach to mental health support that focusses on meeting people's basic rights to community belonging, employment, housing, financial security, and relationships. This lens should not only apply to individual service models but whole of system thinking.

Family and kin also bare the effects of an incomplete service system calling them 'carers' and rendering them responsible within that role rather than recognising this as a failure of the system. A human rights-based approach recognises the inherent rights of family and kin and the fundamental importance of relationships and seeks to deliver full citizenship for people with lived experience of mental ill-health and their family and kin.

Beyond an individualistic and biomedical model of mental illness, the lived experience movement has continued to point to mental health challenges as existing in and directly impacted by the social environment. This is demonstrated through the survivor and recovery movement, followed by calls for acknowledgement of trauma, social determinants more broadly, and the introduction into policy of co-production followed by the development of the Lived Experience workforce (including leadership). Adequate investment in psychosocial services represents a powerful acknowledgement of the need for a more holistic response, which includes addressing the social determinants of mental ill-health.

Addressing mental ill-health in Australia, requires legislators, policy makers and regulators to expand their thinking beyond the health sector to address poverty, inequality, discrimination, housing and employment security and loneliness. Mental health services alone cannot deliver relationships, nurturing families, financial security, homes, purpose, meaning and other foundations, from which people regain contributing lives.

This advice invites governments to make a step forward on the complex journey of transformation to a contemporary whole-of-government service system by investing in evidence-informed and good practice psychosocial services. The evidence is clear. We know psychosocial services work. Now, let's make investments that result in transformational systemic change that will truly support people to thrive.

National Mental Health Consumer & Carer Forum

Executive summary

This paper presents the breadth of evidence-informed and good practice psychosocial services that Australian governments should fund to address the gap in psychosocial services outside the National Disability Insurance Scheme (NDIS).

Psychosocial services support people with mental ill-health in their personal recovery, to connect with their community and what's meaningful for them. This can include support for care coordination, personal recovery, accommodation, education, employment and social and community connection. Psychosocial services also enable carers and family members to participate in employment and engage with the community.

Under the National Mental Health and Suicide Prevention Agreement, Australian governments have committed to estimate unmet need in psychosocial support outside the NDIS and develop future psychosocial support arrangements.[2] Governments are expected to complete this unmet need analysis by March 2024.[3]

This paper provides advice to Australian governments to ensure future investment in psychosocial services provides people with mental ill-health access to a range of evidence-informed and good practice services which support personal recovery and transformational change, rather than maintaining dependency on service provision.

To develop this advice to Australian governments, Mental Health Australia and the National Mental Health Consumer and Carer Forum undertook a literature scan and tested the findings with people with lived experience of mental ill-health, carers, family and kin, service providers, key academics and other stakeholders.

This advice includes psychosocial service principles, models and discrete services.

The section on psychosocial service principles describes principles which should underpin delivery of every psychosocial service. These psychosocial service principles drew heavily on work already undertaken by Community Mental Health Australia and were further tested with stakeholders. Psychosocial services should:

1. Be co-produced, or failing that, co-designed with people with lived experience of mental ill-health, carers, family and kin
2. Be human rights focussed, recovery-oriented, trauma informed, strengths based, person-led, focus on capacity building and be holistic
3. Be accessible
4. Be inclusive and culturally safe
5. Facilitate integration of supports
6. Be time unlimited and flexible enough to respond to need and choice
7. Develop the peer and non-peer psychosocial workforce
8. Be evidence-informed, include robust evaluation and foster innovation
9. Be relational (as opposed to transactional) and, in doing so, be inclusive of carers, family and kin
10. Include supported decision making and safely support dignity of risk.

This paper also provides a list of evidence-informed and good practice psychosocial service models. Models describe the overarching design of service provision, including how services are provided and what services are provided. This section outlines psychosocial service models, which have been shown to effectively support positive outcomes for people with mental ill-health, carers, family and kin. This list draws heavily on two recent systematic reviews and an evidence check of psychosocial services[4] and was tested with key stakeholders.

The psychosocial service models listed are:

- care coordination focussed models
- recovery focussed models
- accommodation focussed models
- vocation focussed models
- education focussed models
- social and community connection-focussed models
- family focussed models
- step up step down focussed models
- models that encourage choice around medication use

- models including partnerships and collaboration between psychosocial services and other services
- models integrated with drug and alcohol services
- social and emotional wellbeing models
- multicultural models.

This advice includes examples and evidence of each of these models in practice.

Finally, this paper outlines discrete psychosocial services. These are psychosocial services that could be delivered either independently or through the above-mentioned models. To develop this list Mental Health Australia and the National Mental Health Consumer and Carer Forum drew on a literature review of effective, evidence-based psychosocial interventions[5] and then tested the list with key stakeholders. Discrete psychosocial services included in this advice to governments are:

- peer-based psychosocial services
- physical health management
- daily living skills
- wellness recovery action plan
- mental health carer respite
- psychosocial support for young people
- psychosocial support for older people
- creative art therapies
- nature-based therapies
- animal assisted therapies
- recovery colleges
- groupwork
- sensory spaces
- time use or occupational balance
- services that link clinical services with psychosocial services.

Australian governments currently have an opportunity to fund services, which don't just maintain dependence on services but instead result in truly transformational change for people with mental ill-health. In order to achieve this, Australian governments will need to understand the richness and breadth of effective psychosocial services, and facilitate genuine co-design on psychosocial service options with people with lived experience of mental ill-health, carers, family and kin, service providers and other key stakeholders.

Mental Health Australia and the National Mental Health Consumer and Carer Forum can bring together a wide diversity of stakeholders across the mental health sector to participate in future policy deliberations around psychosocial services. We look forward to working with Australian governments further in designing this essential component of mental health support.

Recommendations:

1. Australian governments should use the evidence in this advice to governments when considering design and funding of psychosocial services outside the National Disability Insurance Scheme following the unmet needs analysis. Any new psychosocial support investment should align with the Psychosocial Service Principles outlined in this paper.
2. Australian governments must co-design new psychosocial support arrangements with people with lived experience of mental ill-health, carers, family and kin, service providers, key academics and other key stakeholders. The information presented in this paper can form the basis for further consultation.

Introduction and purpose

This paper provides detailed information to governments in Australia on the range of evidence-informed and good practice psychosocial services that could be funded to address the gap in psychosocial services outside the NDIS. It has been developed to directly feed into policy deliberations resulting from the unmet needs analysis of psychosocial support outside the NDIS, which the Australian Government Department of Health and Aged Care along with state and territory governments are currently undertaking.

The psychosocial service sector offers a rich and diverse array of psychosocial services, which, when appropriately resourced and connected with the broader service system, can support people in achieving transformational change. This paper is a starting point for understanding the breadth of psychosocial services, highlighting the wide array of psychosocial services which have demonstrated positive outcomes and are valued by people with lived experience of mental ill-health, carers, family and kin. It is intended to be a living document, which can be drawn on, built upon and tailored to suit the needs of specific jurisdictions or specific groups of people.

This paper outlines psychosocial service principles, psychosocial service models, discrete psychosocial services and highlights considerations for service implementation.

A note on language

Mental Health Australia and the National Mental Health Consumer and Carer Forum acknowledge that language around mental health and psychosocial supports is continually evolving, and that different stakeholders may prefer different language in describing these concepts. In this paper, Mental Health Australia and the National Mental Health Consumer and Carer Forum have retained terminology used by the original authors of cited work.

What are psychosocial services?

Psychosocial services are supports which help people with mental ill-health in their personal recovery, to connect with their community and what's meaningful to them. They are non-clinical services and are provided most frequently by community-based organisations. These services include support for care coordination, personal recovery, accommodation, education, employment, social and community connection among other services. They also enable carers, family and kin to participate in employment and engage with the community.

In consultations for this paper, people with lived experience of mental ill-health and carers, family and kin reported the most helpful aspect of a psychosocial service in their experience was a good relationship with a particular worker, reflecting the inherently relational work of psychosocial services.

Strategic policy context: the psychosocial service ecosystem

When Australia committed to deinstitutionalisation, the country began the process of recognising and honouring the rights and contribution of people with lived experience of mental ill-health. However, the full intention of deinstituionalisation has not yet been fulfilled, and while we have removed most mental health institutions, many people with mental ill-health have been left without adequate supports to thrive in the community.

It is now time to fulfil this reform. One key element of such reform is sound investment in psychosocial services. There is a strong evidence-base of effective psychosocial services to support people in the community, alongside lessons learnt in the first decade of the NDIS.

In 2020, the Productivity Commission estimated that 154,000 people were not able to access the psychosocial services they require, at extreme personal costs in quality of life, as well as broader social and economic costs.[6] The Productivity Commission estimated the funding shortfall for these services to be $610 million per year,[7] and recommended following further analysis of this service gap, that “state and territory governments, with support from the Australian Government, should, over time, increase the quantum of funding allocated to psychosocial supports to meet the estimated shortfall.”[8]

Strongly supported by the sector, Australian governments committed through the National Mental Health and Suicide Prevention Agreement to “work together to develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS”.[9] Australian governments are analysing demand compared to availability of psychosocial supports, with this analysis due to be complete by March 2024.[10] This paper has been developed to provide advice to Australian governments about what types of psychosocial services could be funded to address the gap in psychosocial services outside the NDIS.

There are also other opportunities to harness recent and evolving key strategic policy shifts, to deliver this reform.

For example, the implementation of the NDIS significantly changed the psychosocial services sector. In its first 10 years of operation, the NDIS has been life-changing for many Australians with psychosocial disability. However, transition to the NDIS has also created significant challenges for people with lived experience of mental ill-health or psychosocial disability, carers, family and kin, psychosocial service providers and the psychosocial support workforce both within and outside of the NDIS. The transfer of funding for key psychosocial support programs into the NDIS left chasms in the community mental health sector outside of the Scheme.

As both the Minister for the NDIS, the Hon Bill Shorten MP,[11] and the Co-chair of the NDIS Review Independent Review Panel, Professor Bruce Bonyhady,[12] have acknowledged – Australia needs a strong community mental health system outside the NDIS. There is also support from National Cabinet, with the Commonwealth and State and Territory Governments all agreeing to commission additional Foundational Supports outside the NDIS,[13] which the NDIS Review recommended should include psychosocial supports.[14]

Further, the recommendations of the Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability highlight the need for a human rights-based approach that supports the full citizenship of people with psychosocial disability.

Consideration and implementation of reforms in response to these keystone reviews will take time, but will fundamentally shape the design of psychosocial supports outside the NDIS to meet community need and deliver a vision for a human rights-based approach to mental health support.

This paper contributes to consideration of a future psychosocial support service system. It outlines evidence-informed and good practice services that demonstrate positive outcomes for people experiencing significant mental ill-health. It is offered as a starting point for Australian Governments' considerations, to take the best of what we know already, and adapt this to the current environment in developing a new system which supports ongoing innovation in psychosocial services. It should be accompanied by genuine and thorough consultation on investment in psychosocial services to ensure implementation meets the needs of people with lived experience of mental ill-health, carers, family and kin and integrates with the current service ecosystem.

Method

To inform development of this list of evidence-informed and good practice psychosocial services, Mental Health Australia and the National Mental Health Consumer and Carer Forum conducted a preliminary literature scan, consulted key academics with expertise in psychosocial services and consulted online with over 100 people, including people with lived experience of mental ill-health, carers, family, and kin, Mental Health Australia members, service providers, state and territory peak bodies, researchers and other key stakeholders. In addition, two online surveys were conducted to gather feedback:

- one for people with lived experience of mental ill-health (answered by 147 people)
- one for carers, family and kin of people with lived experience of mental ill-health (answered by 61 people).

Psychosocial services included in this list have been assessed through reviews as having a strong evidence base, or were highlighted through consultations as good practice and were valued by people with lived experience of mental ill-health, and carers, family and kin.

Psychosocial service principles

This section outlines a list of principles, which should underpin psychosocial service delivery. These principles are based on a list of principles developed by Community Mental Health Australia, which were then tested and built upon through consultation with people with lived experience of mental ill-health, carers, family and kin and Mental Health Australia members.

Any psychosocial service should:

1. **Be co-produced, or failing that, co-designed with people with lived experience of mental ill-health and carers, family and kin**:

   Genuine engagement with people with lived experience of mental ill-health and caring for people with mental ill-health results in greater empowerment and ownership of mental health programs and delivers outcomes that target the issues that matter most to people accessing services.[15,16] Program design, implementation and evaluation should be co-designed with people with lived experience of mental ill-health and carers, family and kin.

2. **Be human rights focussed, recovery-oriented, trauma informed, strengths based, person-led, focus on capacity building and be holistic**:

   Human rights focus: Psychosocial service delivery should align with Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities and other related human rights legislation and policy. A human rights' focussed approach assists people to move forward towards greater self-determination, autonomy and independence, reduces stigma and discrimination, supports dignity of risk, facilitates equity and access and recognises lived and living experience as integral to support planning.

   Recovery-oriented: The National Framework for Recovery-Oriented Mental Health Services describes recovery-oriented practice as "the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations."[17] Mental Health Australia members advised that a recovery-oriented approach is inextricably linked with both a trauma-informed approach (see below) and a strengths-based approach (see below). For more information about a recovery-oriented approach see the National Framework for recovery-oriented mental health services: guide for practitioners and providers.

   Trauma informed: the Mental Health Coordinating Council of New South Wales describes Trauma Informed Care and Practice (TICP) as "an approach which recognises and acknowledges trauma and its prevalence, alongside awareness and sensitivity to its dynamics, in all aspects of service delivery."[18] Mental Health Australia members advised that a trauma-informed approach is inextricably linked to a recovery-oriented approach (see above). For more information about trauma-informed care and practice see the Mental Health Coordinating Council of NSW website.

Person-led: Agency is fundamental to mental health recovery. The National Mental Health Consumer and Carer Forum describes person-led approaches as requiring clinicians and services to focus on the individual, not the service. This means:

- "respecting where the individual is at now, their journey, dreams and goals
- matching the services and support with the person's needs
- working in partnership with the individual, families/ carers to ascertain the person's capacities and strengths."[19]

Strengths based: "The Strengths Model is both a philosophy of practice and a set of tools designed to help people set meaningful and important life goals by focussing on the abilities, resources and potentials of people and their communities, and promoting a more optimistic approach to working with individuals with mental illness, and the communities within which they live, learn, work and socialise."[20] Mental Health Australia members advised that this is inextricably linked with a recovery-oriented approach (see above).

Capacity building: Psychosocial services should focus on building capacity of the people they support, rather than maintaining dependency on the service. This should be front of mind when designing the services, when recruiting a workforce skilled to deliver capacity building psychosocial support and when measuring success.

Holistic: Psychosocial services should consider the person as a whole including the biological, psychological, social, cultural, spiritual and environmental elements of their life.

3. **Be accessible**: Psychosocial services should be accessible for people with mental ill-health, carers, family and kin. This includes a range of measures including but not limited to:

    - **ensuring there is a proactive outreach component to program delivery**: As has been well demonstrated in the context of the NDIS, proactive outreach is essential in ensuring equity of access to psychosocial services, especially for people experiencing significant disadvantage such as homelessness.[21,22,23] This type of support should assist people to learn about and access psychosocial services.

    - **ensuring there are low barriers to program entry, including no need for a mental health diagnosis and multiple referral pathways:** the Productivity Commission Inquiry into Mental Health recommended "Access criteria for psychosocial supports should be adjusted such that potential participants would not be required to have a diagnosis of mental illness before approaching a service."[24] In addition, to aid ease of access, there should be multiple referral pathways for services including self-referral, family/friend referral, referral from mental health services and referral from primary health and other services.

- **ensuring services are accessible for people with disability**, including but not limited to people with psychosocial disability.

- **ensuring services can be delivered in a location that meets the needs of the person** accessing the service, including offering services from the person's home or in a place that is easily accessible via public transport and safe.

- **ensuring services are delivered at no cost to the person accessing the service**. Mental health and financial hardship are linked. "People experiencing mental health challenges are twice as likely as those who are not to also be experiencing financial challenges."[25] The Australian Bureau of Statistics reported that in the 2022-23 financial year, 19 per cent of people delayed or did not see a health professional for their own mental health when needed due to cost.[26] Given that people experiencing mental health challenges are more likely to be experiencing financial challenges and that cost is already a barrier to seeking mental health support, it is important that cost is not a barrier to people seeking psychosocial support. Psychosocial supports should be offered at no cost to the person with lived experience of mental ill-health and family, carers and kin.

4. **Be inclusive and culturally safe**: It is imperative that psychosocial services are safe and accessible to everyone in the Australian community, and consider the particular needs of population groups, which experience higher rates of mental ill-health and face higher barriers to accessing care, including but not limited to Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and people from the LGBTIQA+ community.

   In the surveys conducted to inform this paper, only 23 per cent of people with lived experience of mental ill-health and 11 per cent of carers, family and kin said they felt like the psychosocial service respected their culture. There is clearly work to be done to ensure Australian psychosocial services are culturally safe. In line with the Gayaa Dhuwi (Proud Spirit) Declaration, and the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing, "Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice."[27] All psychosocial services should be culturally safe for Aboriginal and Torres Strait Islander people.

   To ensure organisations are effectively meeting the needs of people from culturally and linguistically diverse backgrounds, organisations delivering psychosocial services should also adhere to the Framework for Mental Health in Multicultural Australia. All psychosocial services should be culturally safe for people from culturally and linguistically diverse backgrounds.

In addition, only 37 per cent of people with lived experience of mental ill-health and 19 per cent of carers stated they felt like the psychosocial service they accessed respected their identity. This speaks to the need for the psychosocial service sector to be more inclusive. In line with the National LGBTIQ+ Mental Health and Suicide Prevention Strategy, mental health services should ensure both organisations and staff understand and can appropriately respond to the needs of LGBTIQ+ people.

5. **Facilitate integration of supports**: In the survey informing development of this paper, only 18 per cent of people with lived experience of mental ill-health expressed that their psychosocial service spoke with their clinical service, and it was easy to move between them. In addition, 25 per cent of people with lived experience of mental ill-health said there was only one person to help them when they would have preferred a team of people with different roles to help them. This speaks to the need for better partnerships, collaboration, co-location and integration of teams. It mirrors feedback through the consultations conducted by Mental Health Australia and the National Mental Health Consumer and Carer Forum about the importance of partnership, collaboration, co-location and integration of psychosocial services with other services such as clinical mental health services, NDIS services, drug and alcohol services, physical health services, employment, housing and homelessness, disability, justice and many other sectors.

6. **Be time unlimited and flexible enough to respond to need and choice**: Psychosocial services should be able to increase and decrease in intensity in response to the episodic needs of people living with mental ill-health. In the surveys conducted to inform this paper, 35 per cent of people with lived experience of mental ill-health and 22 per cent of carers and family stated it was easy to increase or decrease intensity of care based on need. In addition, when asked what parts of psychosocial service they accessed were least helpful to them the most common answer for people with lived experience of mental ill-health (61 per cent of people) and carers (54 per cent of people) was that the support provided was time limited.

   It is important that psychosocial services are flexible enough to respond to the intensity of need and at a pace that is commensurate with that need. Psychosocial support should also be available according to the person's need for it, not a predetermined timeframe.

7. **Develop the peer and non-peer psychosocial workforce**: Psychosocial support program design should incorporate development of the peer and non-peer workforces. This could include consideration of support for the workforce to achieve minimum qualification standards. It could also include ensuring funding is adequate to ensure appropriate supervision, continuing professional development and wages that are commensurate with the complexity of work being undertaken.

8. **Be evidence-informed, include robust evaluation and foster innovation**: Evidence should underpin psychosocial service design, implementation and evaluation. For example, this could be implemented through requiring routine collection of data (including on outcomes), informed by consultation with people with lived experience of mental ill-health and carers, family and kin, and allocating funding for program evaluations to ensure a robust evidence base.

   A balance should be struck between ensuring psychosocial services are evidence-informed and enabling safe fostering of innovation in service delivery. This could occur through allocating a proportion of funding to pilot innovative approaches. Routine data collection should be required for innovative pilots alongside robust evaluation to establish an evidence base. There should also be a clear process to scale up innovative approaches which are successful at achieving positive outcomes for people with psychosocial disability.

9. **Be relational as opposed to transactional and in doing so be inclusive of carers, family and kin**: When asked what parts of psychosocial service were most helpful to them, the most common response from people with mental ill-health (63 per cent) and carers, family and kin (65 per cent) was that the person accessing the service had a good relationship with a particular worker. Psychosocial services should be delivered in a manner that nurtures building a safe and therapeutic relationship between the person and the worker. It should also consider and help to nurture the key positive relationships in a person's life. Psychosocial services should not take a transactional approach whereby the emphasis is on an exchange of value rather than focussing on the importance of building relationships themselves.

   In taking this relational approach, psychosocial services should be delivered in a manner that is inclusive of family, carers and kin where this is agreed with the person with lived experience of mental ill-health. Service delivery should be cognisant of and support healthy development of key relationships in the person's life, acknowledging the strong impact relationships can have on mental ill-health.

10. **Include supported decision making and safely support dignity of risk**: Supported decision making is a process of assisting a person to make their own decisions, so that they can develop and pursue their own goals, make choices about their life and exercise more control over things important to them. Access to supported decision making maximises a person's autonomy and independence and minimises the need for substitute decision-making and coercive practice. Supported decision making should be built into psychosocial services as a core skill for psychosocial support workers as well as the workforce across the service system.

    Psychosocial services should also provide opportunities for positive risk-taking, recognising people's right to make their own choices, and that even with the best planning, important life experiences can come with an element of risk. This must be inherently balanced with safety and providers' duty of care, and the tensions around this should be discussed and worked through with mutual respect.[28],[29]

Psychosocial service models

This section outlines psychosocial service models, which have been shown to effectively support positive outcomes for people with mental ill-health and/or carers, family and kin. Information included in this section is largely drawn from:

- a 2023 systematic review of community-based models of care facilitating the recovery of people living with persistent and complex mental health needs[30]
- a 2022 systematic review of community-based social interventions for people with severe mental illness[31]
- a 2017 evidence check on models of care for people with severe and enduring mental illness.[32]

It also includes additional information elicited through conversations with key academics and consultation with people with lived experience of mental ill-health, carers, families and kin, Mental Health Australia members and other key stakeholders.

The psychosocial service models described below are:

- care coordination focussed models
- recovery focussed models
- accommodation focussed models
- vocation focussed models
- education focussed models
- social and community connection-focussed models
- family focussed models
- step up step down focussed models
- models that encourage choice around medication use
- models including partnerships and collaboration between psychosocial services and other services
- models integrated with drug and alcohol services
- social and emotional wellbeing models
- multicultural models.

It is important to note that not all the examples below adhere to all the above-mentioned psychosocial service principles. They are included only as good practice examples. Any new psychosocial service should be designed with the above-listed psychosocial service principles in mind.

Care coordination focussed models

Care coordination is a critical component of psychosocial support delivery. One example of a care coordination approach is the Partners in Recovery (PIR) program.

Example: Partners in Recovery

PIR was an initiative funded under the Australian Government's 2011-2012 mental health reform until funding for this program was rolled into the NDIS. "PIR aims to better support people with severe [serious and persistent mental illness] with complex needs, and their carers and families, by getting services and supports from the multiple sectors with which they may come into contact and from which they could benefit to work in a more collaborative, coordinated and integrated way."[33] The program also had a system reform function whereby PIR organisations were required to undertake system reform projects to move local and regional systems towards those that support recovery and person centred delivery.

The 2015 Evaluation of PIR stated "PIR is proving to be an innovative model that is delivering transformational change for many clients with severe and persistent mental illness with multiple complex needs via a recovery based approach that is person centred and focussed on coordinating and integrating services to deliver improved outcomes."[34] PIR has also been shown to reduce unmet needs[35] and improve personal recovery,[36] be valued by people using the service and improve access to other services.[37]

The 2015 evaluation stated it was too early to tell what the outcomes might be for the system reform element of the program.[38] However many stakeholders consulted in development of this paper noted this unique aspect of the PIR program as one of its most important features.

Recovery focussed models

As mentioned in the principles above, all psychosocial support services should be recovery-oriented. However, there are many programs for which, recovery support is the main focus of support delivery.

Example: Personal Helpers and Mentors

The Personal Helpers and Mentors (PHaMs) program aimed to provide "non-clinical community-based one-on-one team-based support using a strengths-based, recovery approach."[39] These services were provided to people who were 16 years old or over, had a mental illness and experienced severe functional impairment because of that illness. In recognising the dearth of services in remote areas, the age limit didn't apply to people living in remote areas.[40] The funding for this program was folded into the NDIS.

PHaMs "Clients reported improved confidence, more knowledge about their condition, more connectedness with family members, and better social and community inclusion. They reported increased ability to manage their lives, a sense of achievement and hope in the future. Overall, they reported more resilience, problem solving skills, healthier lifestyles, improved quality of life, improved security, and improved family and community relationships. Furthermore, the carers and relatives of PHaMs clients also reported significant progress, more understanding of mental health conditions, of how to pick up signs of deterioration, how to live and relate more effectively to clients, and to understand recovery principles and processes."[41]

Example: South Australian Individual Psychosocial Rehabilitation and Support

The Individual Psychosocial Rehabilitation and Support Service operates from a recovery-oriented approach using partnership between non-government organisations and government mental health services. The services provided through this model include assistance to engage with meaningful activities, housing support, social engagement, daily living skills and support to transition from facility-based services to the community. The program has been shown to result in measurable improvements in mental health, and decreased hospital admissions and length of stay.[42]

Accommodation focussed models

At least 31,000 people across Australia living with mental ill-health are experiencing or at risk of homelessness and have an unmet need for long-term housing.[43] Many more people with experience of mental illness are living in unsuitable accommodation, and over 2,000 people are stuck in institutional care because other accommodation is not available.[44]

The Trajectories research highlighted the importance of ensuring mental health support is integrated with housing support.[45] There are many models of care which focus on ensuring stable housing for people with mental ill-health including but not limited to housing first, housing with family, and living in social housing or private rental.[46]

Example: Housing First (Victorian Doorway program)

The Housing First model has a strong evidence base.[47] "Housing First is a consumer-driven model for people [experiencing homelessness and] with mental health and substance use problems that houses participants immediately to permanent housing in the community, without any preconditions, before collaborating with them to address health, mental health, addiction, employment, social, familial, spiritual, and other needs."[48] A report by Mental Health Australia and KPMG estimated that "for every $1 spent on Housing First models, $3 is generated in the short term and $6.70 is generated in the longer term."[49]

An example of the Housing First model in practice is the Doorway program in Victoria. This program is targeted towards people at risk of/or homeless in Victoria's public mental health system. Participants in the program choose properties through the open rental market and receive rental subsidies, assistance, advocacy and brokerage support from a Housing and Recovery Worker.[50] The Doorway program has been shown to improve housing and health outcomes and reduce length of stay in hospital.[51]

Example: New South Wales Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) and HASI Plus

Another example of accommodation focussed models of psychosocial supports is the combination of CLS, HASI and HASI Plus in New South Wales. These programs are delivered through partnerships between Local Health Districts and specialist mental health community managed organisations. The programs assist people to work towards recovery goals. They assist with daily living activities (including maintaining tenancies) and access to other services. People participating in the HASI program are also supported to apply for secure housing. People participating in the HASI Plus program receive similar supports but at a greater intensity and also move into a community accommodation site, however these sites are only offered in a limited number of locations.[52]

The combination of HASI and CLS programs have been shown to improve participants' wellbeing, help people better manage their mental health, assist with people's physical health, increase social inclusion and assist with finding secure housing.[53] It has also been shown to reduce hospital admissions and length of stay.[54] The programs' evaluation found that "programs are generating more in cost offsets than the cost of the programs…"[55]

Similarly, participation in HASI Plus saw a decrease in hospital admissions and length of stay[56] and the program was found to be cost effective.[57] The success factors for this program identified by a 2022 evaluation were:

- "the access to safe and secure housing as part of the service model
- intensive on-site supports
- strong local partnerships between [community managed organisations] and [Local Health Districts]; and
- the flexible, person-centred approach to service provision."[58]

Ensuring people with mental ill-health have access to safe housing options requires a multipronged approach from government including increasing available housing options, providing support to sustain tenancies and a focus on early intervention and prevention.[59] Psychosocial services can play a pivotal role in this overall approach through the provision of psychosocial support that is integrated with housing support. It is important that there is a range of options available to support people with mental ill-health into safe housing as one approach will not be suitable for all.

Vocation focussed models

Engaging in meaningful and contributing activity, including employment, is associated with positive mental health and wellbeing. Employment can be helpful in preventing mental ill-health and in promoting recovery and wellbeing for people experiencing complex mental health challenges. There are a range of employment supports designed to assist people with lived experience of mental ill-health to obtain and sustain employment.[60]

Example: Individual Placement and Support

One of the most frequently evaluated vocation focussed models is the Individual Placement and Support (IPS) program. It "focuses on eight core practice principles that underpin the delivery of support to participants: competitive employment, systematic job development, rapid job search, integrated services, benefits planning, zero exclusion, time unlimited supports and worker preferences. Despite its highly defined nature, the IPS centres on participants' preferences, and tailors unique, individualised responses to a person's goals and interests."[61]

A review by Mental Health Australia and KPMG in 2018 concluded that "There is a strong evidence base behind the Individual Placement and Support model…"[62] and the intervention is "effective in supporting individuals with severe mental health issues gain meaningful employment".[63] It estimated that for every $1 spent on Individual Placement and Support the return on investment would be $1.80 in the short term and $2.30 in the long term, accounting for health and employment savings alone.[64]

While the IPS model has been highly evaluated, it will not be a suitable for everyone. It is important to ensure there is a range of vocation focussed psychosocial support options available. For example, other models include (but are not limited to) support for employment through clubhouses, social enterprises[65] and supported employment.[66]

In addition to the provision of a broad range of employment support, a comprehensive approach is required to address unemployment among people with lived experience of mental ill-health. This should include supporting Australia's workplaces to be mentally healthy, addressing stigma and discrimination, improving insurance, compensation and return to work support and improving the way the NDIS supports people with psychosocial disability to gain employment.[67]

Education focussed models

Supported education encourages educational goals among people with mental ill-health.[68] It can commonly include specialised and dedicated staffing, one-on-one and group skill building, activities, assistance with navigating the academic setting and coordinating different services, and linkages with mental health services. [69] A recent American review of supported education studies noted a positive impact of supported education on educational functioning of participating students with psychiatric disabilities. It also found positive effects on time spent in education, interpersonal skills and sustained attention.[70] Supported education has been shown to be a promising practice but more research is needed on its effectiveness.[71,72,73]

Example: The Bridge Program

The Bridge Program incorporates principles of supported education and supported employment. It is designed to assist people with mental ill-health to achieve higher education and employment goals. A study of the program concluded that such a program, can assist people with mental ill-health to achieve higher education and employment goals.[74]

Social and community connection-focussed models

Harvey et al (2023) described social and community connection-focussed models as those with "a clear focus on social or community connectedness outcomes."[75] In their review this primarily included studies examining the effectiveness of Clubhouses.

Example: Clubhouse

"A clubhouse is a community-based location designed to support the recovery of people living with serious mental illness… Each clubhouse provides a restorative environment for people whose lives have been severely disrupted because of their mental illness…

… In each clubhouse, an intentional community is created, where members and staff work together, side-by-side, to carry out all daily operations of the clubhouse. Members are also given access to crisis intervention services when needed and are connected with resources to support their basic needs, including support with employment, relationship building, education, housing, and daily meals."[76]

Involvement in clubhouses has been shown to significantly improve functional outcomes and social cognition.[77] Harvey et al also note that "Socially delivered interventions, such as Clubhouse, are valued by participants as supporting recovery."[78]

Family focussed models

Mental Health Australia members raised the importance of family focussed supports for families of people with mental ill-health. Three examples are included below. Open dialogue was the most frequently raised by people consulted in relation to this project. The New South Wales Family and Carer Mental Health Program and support for siblings were also raised during consultations.

Example: Open Dialogue

Open Dialogue is "an integrative approach that embodies systemic family therapy…and incorporates some psychodynamic principles. It embraces a network perspective, bringing together both social and professional networks, to provide continuity of psychological care across the boundaries of services. It encourages families to meet immediately and frequently after referral to openly explore acute mental health crises. The approach aspires to create a space where decision making is transparent and service users are able to find new words for their experiences. [Open Dialogue] privileges community treatment over hospitalisation."[79]

In relation to the evidence base for open dialogue, initial findings are promising but better quality research is needed to establish a stronger evidence base for this model.[80]

Example: NSW Family and Carer Mental Health Program

Through the New South Wales Family and Carer Mental Health Program, community managed organisations provide "community based education and training, individual support and advocacy services, and planning and infrastructure support for mental health carer support groups."[81] An evaluation of the program found that the majority of carers accessing the program reported the services and support offered by the program had a positive impact on their health and wellbeing and on the person they support. The program also increased the capacity of mental health services to work with families and carers and resulted in decreased levels of stress among the carers it supported.[82] Over time carers reported improved health, improvements to the caring role itself, increased time to themselves and generally feeling better.[83]

Example: The Sibling Support Program

The Sibling Support Program uses a combination of peer support, parent mentor guidance and clinician-led group therapy to assist families and in particular siblings of people with mental ill-health. The program has been shown to result in decreased feelings of isolation, gains in knowledge of mental ill-health and coping skills, and more positive thinking after program participation. Siblings feel better after meeting with peers and learn coping strategies.[84]

Step Up Step Down focussed models

"Step Up Step Down… services are recovery-focused residential programs that provide a 'step-up' from the community into a highly supportive environment that aims to minimise the risk of readmission to inpatient mental health facilities. The service provides a 'step-down' for people being discharged from inpatient mental health facilities who would benefit from safe and comfortable voluntary environment from which to be supported to transition back into the community."[85]

Step up Step Down services have been shown to improve people's mental health and decrease mental and behavioural problems, problems with relationships, and depressed moods.[86] They have also been shown to improve self-reported psychological distress and work and social adjustment.[87]

Example: Victorian Prevention and Recovery Care Service

The Victorian Prevention and Recovery Care services provide a mix of clinical and psychosocial support. They operate with a recovery focus, are short-term and residential. Prevention and Recovery Care services have been shown to significantly improve participants' mental health.[88]

Models that encourage choice around medication use

While medication can be very helpful for many people experiencing mental illness, for many others medication can be ineffective or side effects can be too significant.[89] Given this, there is a need to consider psychosocial services that support low or no medication approaches.

Example: Soteria

Soteria involves the creation of a space for people experiencing mental illness or distress. It is a community-based recovery-oriented model. The approach usually includes "primarily non-medical staffing; preserving resident's personal power, social networks, and communal responsibilities; finding meaning in the subjective experience of psychosis by 'being with' clients; and no or minimal use of antipsychotic medication (with any medication taken from a position of choice and without coercion)."[90]

A systematic review of the Soteria Paradigm for the treatment of people diagnosed with schizophrenia found that "the Soteria paradigm yields equal, and in certain specific areas, better results in the treatment of people diagnosed with first- or second-episode schizophrenia spectrum disorders (achieving this with considerably lower use of medication when compared with conventional, medication-based approaches)."[91]

Models including partnerships and collaboration between psychosocial services and other services

When asked what parts of psychosocial service were most helpful to them, one of the most common responses from people with lived experience of mental ill-health and carers, family and kin, was that there was a team of people with different roles that were able to help them. This speaks to the importance of multidisciplinary teams in the provision of psychosocial services.

Psychosocial service evidence reviews commonly include reference to case management, intensive case management, assertive community treatment and flexible assertive community treatment.[92] However, these models have been intentionally excluded from this list as some people consulted felt these models were too clinical in nature to be considered psychosocial services. It is important to note that there is scope within these more clinical frameworks for psychosocial service enhancements that support personal recovery.[93] People consulted by Mental Health Australia and the National Mental Health Consumer and Carer Forum noted this could include integration with psychosocial services or in fact delivery of psychosocial interventions through the more clinical models. In fact, this paper highlights the importance of integration between clinical and non-clinical models of care as a core principle underpinning effective psychosocial service delivery.

There are examples of services which successfully integrate mental health and psychosocial services.

Example: South Australian Intensive Home Based Support

The South Australian Intensive Home Based Support program provides "individually tailored, short term psychosocial support of generally 3 months".[94] It includes clinical and non-clinical support, case management and coordination. The program has been shown to significantly reduce psychiatric admissions and length of stay in hospital.[95]

Example: New South Wales LikeMind pilot

Another example is the LikeMind Pilot in New South Wales. This pilot aimed to promote integrated service delivery across mental health, primary health, drug and alcohol and vocational/social needs including employment and housing.[96] While an evaluation found there were issues with integrating services between Local Health Districts and Community Managed Organisations, the LikeMind pilot was successful at reaching people experiencing moderate to severe mental illness. It was also shown to decrease psychological distress.[97]

Example: Victorian Early Intervention Psychosocial Support Response

The Early Intervention Psychosocial Support Response program in Victoria provides support to people for up to 12 months in partnership with health and other local services, focussing on psychosocial functioning, including sustaining housing and service coordination.[98] An evaluation conducted by Mind found that the program was assisting people to make progress towards their goals and generally improve their lives.[99]

Example: Gold Coast Transitional Recovery Service

The Gold Coast Transitional Recovery Service is "aimed at not only treating the mental illness but also increasing well-being in the context of the person's experience of recovery."[100] It is similar to a step-up step-down service in that it provides short term residential treatment, psychosocial rehabilitation and stabilisation and management of illness.[101] A review of the service found that there is a reduction in the number of admissions to mental health hospitals in the six months following participation in this program and in addition people's self-rated recovery improved significantly from entry to exit of the program.[102]

Models integrated with drug and alcohol services

People consulted by Mental Health Australia and the National Mental Health Consumer and Carer Forum identified the high comorbidity between alcohol and other drug use and mental ill-health. They expressed the importance of ensuring that psychosocial supports are integrated with supports designed to assist with alcohol and other drug use.

Example: New South Wales Alcohol and Other Drug Continuing Coordinated Care Program

An example of a program that aims to better coordinate between psychosocial and alcohol and other drug use supports, is the New South Wales Health Continuing Coordinated Care program. It “provides case management to coordinate care for people experiencing alcohol and other drug (AOD) and other significant health and social issues that cannot be addressed by their AOD treatment team alone.”[103] Psychosocial services offered under this program focus on prevention and minimisation of harm associated with alcohol and other drug use.[104] An evaluation of the program found that program participants reported an increase in number of days of work and number of days of study. The program has also been shown to reduce the risk of homelessness and domestic violence and there was a decline in injecting behaviours.[105]

Social and emotional wellbeing models

The social and emotional wellbeing approaches can be understood as "a broad framework which encompasses specific cultural iterations of Indigenous healing practices and epistemologies across the country."[106] Social and emotional wellbeing approaches "emphasise the importance of healthy holistic connections to spirituality, Country, culture, community, family and kinship, body, and mind and emotions as the source of wellbeing."[107] There are many examples of good practice in social and emotional wellbeing, some of which are outlined in documents collated by the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention Clearinghouse, Healing and Social and Emotional Wellbeing page.

Example: Yorgum Family Support Service in Western Australia

Based in Western Australia, Yorgum is an Aboriginal Community Controlled organisation, which provides services to "empower Aboriginal people, their families and communities to have the skills and supports to improve and maintain their social and emotional wellbeing".[108] The Family Support Service in particular provides "intensive Family Support, Indigenous Family Safety and Building Solid Families". [109] This includes "social and emotional wellbeing (SEWB) services including culturally secure information, support and advice to Aboriginal communities particularly those affected by trauma, grief and loss, mental health challenges and at risk of self-harm."[110] "Over 90 per cent of clients say that working with Yorgum has improved their knowledge of [social and emotional wellbeing] and their knowledge of support services available to them."[111]

Example: Children's Ground

Children's Ground is a First Nations Organisation delivering "an innovative approach to education, health and employment services." [112] It is designed, delivered and evaluated by the local community.[113] The organisation employs early childhood educators and works in partnership with local schools.[114] The program has been shown to increase the number of children engaged in early learning, improve children's physical and emotional health and increase employment of parents.[115]

Multicultural models

Australia is a multicultural society, and psychosocial supports should address the needs of people from culturally and linguistically diverse backgrounds. There is a need both for all psychosocial services to be culturally safe and for tailored programs to provide psychosocial services for specific communities.

Example: New South Wales Mental Health Community Living Supports for Refugees program

The New South Wales based Mental Health Community Living Supports for Refugees program assists refugees and asylum seekers with mental ill-health to recover and live independently in the community. It provides "trauma-informed, recovery-oriented, and culturally safe and responsive psychosocial supports".[116] It aims to improve the mental health, wellbeing and functioning of people with lived experience of mental ill-health, increase their social participation and community integration and prevent acute mental health crisis.[117]

People do not need a formal diagnosis to be eligible for the program. It is offered to refugees and asylum seekers within the first 10 years of arriving in Australia. The program provides support to the whole family. A 2022 Evaluation of the program found that people report that the program is easy to engage with and they find that it meets their needs.[118] Further evaluation is needed to quantify the health and wellbeing outcomes.

Discrete psychosocial services

Following are examples of psychosocial services that could be delivered either independently or through the above psychosocial service models. This list is largely drawn from a literature review of effective, evidence-based psychosocial interventions undertaken by The University of Melbourne and Mind in 2016.[119] It also reflects information provided by key academics, people with lived experience of mental ill-health, carers, family and kin and Mental Health Australia members during consultations to inform development of this paper.

The psychosocial services included in this list are:

- peer-based psychosocial services
- physical health management
- daily living skills
- wellness recovery action plan
- mental health carer respite
- psychosocial support for young people
- psychosocial support for older people
- creative art therapies
- nature-based therapies
- animal assisted therapies
- recovery colleges
- groupwork
- sensory spaces
- time use or occupational balance
- services that link clinical services with psychosocial services.

It is important to note that this list intentionally excludes evidence based psychological interventions for treatment of mental ill-health. The Australian Psychological Society has already undertaken significant work to outline evidence-based psychological interventions, which can be found here.[120]

Peer-based psychosocial services

This paper uses the term peer-based psychosocial services to describe those interventions which are delivered primarily by a lived experience (peer) worker. "Lived Experience workers draw on their life-changing experiences of mental or emotional distress, service use, and recovery/healing, and their experiences, or the impact of walking beside and supporting someone through these experiences, to build relationships based on collective understanding of shared experiences, self-determination, empowerment, and hope."[121] The outcomes of peer support programs vary greatly as they are related to the type of program as much as to differences between professional or peer provision. However, it appears that Peer Support is particularly effective in encouraging recovery and restoring hope.[122]

Example: New South Wales Peer Navigation Project

One example of a peer delivered service is the New South Wales Peer Navigation Project. "The primary purpose of this project was to examine whether peer navigators could leverage their personal lived experience of mental health issues and their deep community connections and familiarity with local services, to help individuals in accessing the most suitable care and support."[123] "These individuals play a pivotal role in strengthening connections among mental health and physical health services as well as essential human services. They offer a unique blend of informal, community-based, social service, cultural and clinical support."[124] The project undertook four pilots in New South Wales and evaluated each separately. The evaluations elicited positive feedback on the program often centring on the role that lived experience and ease of access played in assisting people participating in the program to engage with services.[125]

Example: Victorian Safe Haven Café

The Victorian Safe Haven Café offers an alternative environment to hospital emergency departments for people experiencing mental ill-health.[126] The café was designed by people with lived experience of mental ill-health and is staffed by clinicians, peer support workers and volunteers. An evaluation of the café found it reduced Emergency Department presentations and it was more cost effective than emergency departments. It also found the café builds a sense of social connectedness and provides improved consumer experience.[127]

Physical health management

Four out of every five people living with mental illness have a co-existing physical illness, and people with experience of severe mental illness have a lower life expectancy than the general population. [128] Physical health management is therefore extremely important for people with serious mental illness. There are a large range of interventions designed to improve the physical health of people with mental ill-health.[129] Some examples include physical therapy and exercise, diet and nutrition and smoking cessation.[130]

Exercise has been shown to be moderately effective in reducing symptoms of depression, [131] negative symptoms of schizophrenia and also improve physical health of those in the exercise group.[132] Aerobic exercise, strength exercises and yoga have been shown to reduce psychiatric symptoms, state anxiety and psychological distress and improve health related quality of life.[133] Healthy diets have been shown to reduce the risk of depression.[134] Some smoking cessation treatments have also been successful in reducing nicotine dependence among people with schizophrenia.[135]

Daily living skills

The UK National Institute for Health and Care Excellence guideline on 'Rehabilitation for adults with complex psychosis' recommends the provision of "activities to help people with complex psychosis develop and maintain daily living skills such as self-care, laundry, shopping, budgeting, using public transport, cooking and communicating (including using digital technology)."[136]

Wellness recovery action plan

"The Wellness Recovery Action Plan... is a group-based and peer-facilitated intervention that encourages people to plan for greater wellbeing, and also to plan in advance to prevent relapse and recover well from crises."[137] A 2017 Evidence Check found this intervention had been associated with "reduced psychotic symptoms and increased hope compared to [treatment as usual]."[138]

Mental health carer respite

It is widely accepted that respite is critical for mental health carers. It helps with sustainability of the caring role[139] as well as the physical health[140], mental health[141], social participation[142] and economic participation[143] of the carer themselves.

Psychosocial support for young people

The terms of reference set for the Australian Government's analysis of unmet psychosocial support need include the 12-24 age group.[144] Tailored psychosocial support for young people can improve social and functional outcomes as well as assisting them to access mental health supports.[145]

Example: Early Psychosis Youth Services Program's Functional Recovery and Group Programs

One example of psychosocial support targeted specifically to young people is the Early Psychosis Youth Services (EPYS) Program's Functional Recovery and Group Programs. The program includes activities aimed to restore or maintain the normal functional trajectory of the young person including vocational function, educational function and social function.[146] An evaluation of the overall program (including both the clinical and psychosocial elements) found that "the EPYS Program was effective in achieving improved outcomes for some young people."[147] The functional recovery and group programs themselves were reported to be a "key factor in achieving sustainable outcomes for clients".[148]

Psychosocial support for older people

The terms of reference set for the Australian Government's analysis of unmet psychosocial support need include an option to explore inclusion of support need for people aged 65+ years.[149] Continuity of care and choice in support options for people in Australia as we age must be a key component of our psychosocial service system.

Example: Helping Older People Experience Success – Individually Tailored

An example of psychosocial support tailored to older people is the Helping Older People Experience Success – Individually tailored (HOPES-I) program. It is a "group based skills training program shown to improve community functioning, psychiatric symptoms, self-efficacy and receipt of preventative health."[150] Participants in this program have been shown to have significant improvements on outcome measures related to their baseline impairments in functioning.[151]

Creative art therapies

People consulted by Mental Health Australia and the National Mental Health Consumer and Carer Forum noted creative art therapies as a useful practice in mental health recovery. These therapies can include one or more of a large variety of mediums, for example visual art, music, dance, drama, writing etc. A review of the research in relation to creative art therapies found they show potential as a relatively low risk and high benefit intervention to minimize symptoms and maximise functioning in individuals with serious mental illness.[152]

Nature-based therapies

People consulted by Mental Health Australia and the National Mental Health Consumer and Carer Forum noted nature-based therapies as an important practice. An example of such therapies is nature-based walking interventions. A recent systematic review found that nature-based walking interventions can improve adults' moods, sense of optimism and mental wellbeing. They can also mitigate stress, anxiety and negative rumination.[153]

Animal assisted therapies

People consulted by Mental Health Australia and the National Mental Health Consumer and Carer Forum noted animal assisted therapies as a valuable support. Although research is still scarce for this type of therapy, some positive effects have been documented for Animal Assisted Therapy, including having a significant effect on the improvement of psychiatric patients' socialization and a variety of other psychological benefits.[154]

Recovery colleges

"Recovery colleges are an education-based approach to supporting mental health recovery through a framework of shared learning and co-production..."[155] Recovery Colleges are "an adult learning centre at which all courses focus on an individual's management of mental illness and promote self-directed individual recovery. Recovery Colleges aim to help people with mental illness regain control of their lives, manage their illness, and participate more in the community"[156]

Recovery Colleges have "...shown success in improving outcomes for consumers. Studies from the United Kingdom show the colleges contribute to consumers achieving their recovery goals and improving their quality of life and wellbeing. They are also cost-effective."[157]

Groupwork

People consulted by Mental Health Australia and the National Mental Health Consumer and Carer Forum, noted the importance of community-based group work as an element of psychosocial support. Programs that support people to connect with social groups have been found to successfully increase social participation and mental wellbeing.[158] People with lived experience of mental ill-health and recovery can play a particularly powerful role through such groups, empowering others in their recovery journeys.[159]

A review of outcome studies on groups facilitated for people living with serious mental illness, noted that although the research base is limited, in general group work is as effective as individual work, if not more so.[160] In addition, a recent systematic review of community psychosocial group interventions for adults with intellectual disabilities and mental health conditions found that people's outcomes could be improved when the group had a creative element, multiple activities over a short period of time with breaks and group rules.[161]

Sensory spaces

Sensory spaces are physical environments designed to support people to emotionally regulate and reduce distress. These can be useful psychosocial services either outside or within a clinical setting. A recent systematic literature review analysing the use of sensory rooms in adult psychiatric inpatient settings found that patient and staff experiences suggest sensory rooms "support emotional regulation, promote self-management, and positively impact the overall patient admission experience and ward environment."[162] The review also identified that more research is needed about what works, for who and in what circumstances for the design of sensory rooms.[163]

Time use or occupational balance

Time use or occupational balance involves helping people manage and structure their daily routines to achieve a healthy balance between work, leisure and self-care activities. A study of one such program called Balancing Everyday Life (BEL) concluded that the BEL program was more effective (when compared with care as usual) in terms of activity engagement and on general quality of life.[164]

Services that link primary health care services with psychosocial services

People consulted in development of this paper noted the importance of ensuring clinical services (such as General Practitioners and Psychiatrists) are well linked to psychosocial services. Two examples of services designed to do this are social prescribing and the Mental Health Nurse Incentive Program.

Example: Social Prescribing

Social prescribing often involves a health practitioner referring a person to a social prescribing professional, commonly referred to as a link worker. The link worker works with the person from a strengths perspective to identify non-clinical services and activities which might assist the person. The types of services or activities a person can be linked to can include arts, books (including book clubs), education (including life skills such as money management, cooking, organisational skills), exercise, increasing contact with nature, healthy living initiatives, employment services and housing services.[165]

Emerging international literature on social prescribing identifies people with lived experience of mental ill-health as a group that could benefit from social prescribing.[166] There is promising emerging evidence showing positive outcomes for patient wellbeing, community connections, healthy living, reductions in anxiety and depression, empowerment, self-care and resilience to manage health and psychosocial problems.[167]

Example: Mental Health Nurse Incentive Program

The Mental Health Nurse Incentive Program funded community-based practices, private psychiatric practices and other organisations to employ mental health nurses to help provide coordinated clinical care for people with severe mental disorders.[168] Feedback from Mental Health Australia members indicates this program often involved coordination of psychosocial supports. An evaluation of the program found that program participants on average had fewer admissions to mental health hospitals, increased involvement in social activities, improved educational outcomes and improved family interactions.[169]

Considerations for implementation

This section outlines those areas where further work is required, particularly in relation to implementation of psychosocial services.

Clearly identified lines of responsibility

Implementation of psychosocial services has historically been an area of murky responsibility, with both the Commonwealth and States and Territories funding psychosocial services. It will be important for the Australian Government, along with state and territory governments to create clear lines of responsibility for funding, planning, implementation, collaboration and evaluation of psychosocial services. This could occur through The National Mental Health and Suicide Prevention Agreement, with the agreement itself stating that "further clauses relating to future arrangements for psychosocial supports outside the NDIS will be developed after the analysis work has been completed and attached to [the National Mental Health and Suicide Prevention Agreement] as a Schedule."[170]

Accountability and continuous improvement

In addition, Australian governments should consider what accountability mechanisms would be most suitable to ensure the program is delivering on its aims. This could occur through both the National Mental Health and Suicide Prevention Agreement governance mechanisms, with inclusion of the sector, and a re-focussed role of the National Mental Health Commission on monitoring and reporting. There should be a mechanism to ensure lived experience leadership in holding government to account for success of the program.

Continuous improvement and evaluation should also be built into psychosocial service program design from the beginning, and this should be heavily informed by consultation with people with lived experience of mental ill-health and carers, family and kin. There should be a clear process whereby psychosocial services are able to adjust as more is learnt about psychosocial support delivery.

There should also be adequate investment in research on psychosocial services. Psychosocial services should be able to demonstrate their efficacy to ensure successful programs are maintained in the long term. At the same time, governments should ensure there is sufficient investment in innovation so that new and innovative services and approaches can be piloted, tested and if successful, expanded to meet demand.

As a part of this focus on accountability and continuous improvement, organisations delivering psychosocial services should be encouraged to develop and nurture a 'just culture'. This includes an open, trusting and supportive professional atmosphere, tolerance of human error and ensuring effective systems put in place to guard against mistakes being made, investigations around mistakes being focussed on organisational improvement rather than ascribing blame and appropriate support for staff who make mistakes.[171]

Workforce

Australian Governments will also need to consider how to continue to develop the workforce required to deliver psychosocial services. There is a lack of data about the full workforce delivering psychosocial support services.[172] Consultation with Mental Health Australia members, people with lived experience of mental ill-health and carers indicates the workforce required to deliver psychosocial services in Australia is broad encompassing peer workers and mental health workers alongside allied health and clinical professionals. The peer workforce in particular should be a focus for development, noting the National Mental Health Workforce Strategy has committed to "create incentives for employers to increase the numbers of designated Lived Experience (Peer) employees across all organisational levels."[173]

In funding models, governments should explicitly consider whether there is adequate funding for organisations to continue staff professional development, including allowing for appropriate professional supervision and training and allowing for wages that are commensurate with the complexity of work undertaken. In addition, appropriate governance arrangements will need to be in place to ensure the workforce upholds the standards necessary to deliver quality psychosocial support.

Tailored to location and responsive to diversity

People consulted during the development of this paper raised the importance of ensuring the psychosocial services commissioned are suitable for the location they are implemented within. This should include careful consideration of the existing services and gaps in a particular location and ensuring a diversity of people are consulted including relevant community leaders and particularly people with lived experience of mental ill-health, carers, family and kin. This will be particularly important in regional and remote locations where availability of community managed organisations and/or workforce is scarcer and services may need to draw on the expertise of other local services or existing social infrastructure, which may not necessarily be mental health specific (for example Neighbourhood Centres). It will also be important in culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander communities to ensure psychosocial services are adequately tailored to meet local need.

This paper draws heavily on four reviews. These four reviews reported on studies on psychosocial services largely from Australia, the United States of America, Canada and Western European countries. In future consultations, there would be value in consideration of other studies on psychosocial services from other countries, cultures and contexts.

Funding mechanisms

Careful consideration should also be given to the type of funding mechanisms that would be most suitable to fund any psychosocial support program. For example, the Productivity Commission found that short funding cycles create extreme uncertainty and inefficiency for providers, and in turn can negatively affect people accessing services and staff wellbeing and retention. It recommended "The Australian and State and Territory Governments should extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years, and ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle." It also stated that "The Australian Government should require Primary Health Networks to enter into longer-term contracts when commissioning psychosocial services, in line with the longer funding cycles that have been introduced more generally for Primary Health Networks"[174]

Conclusion

This paper provides advice to Australian governments on the wide variety of evidence-informed and good practice psychosocial services which could be funded to address the gap in psychosocial services outside the NDIS.

Australian governments have an opportunity to fund services, which, when appropriately resourced and connected with the broader service system, don't just maintain dependence on services but instead result in truly transformational change for people. To do this will require not only understanding the richness and breadth of psychosocial services that could potentially be funded but also engaging in genuine co-design on psychosocial service options with people with lived experience of mental ill-health, carers, family and kin, service providers and other key stakeholders. This is necessary to ensure any future funding is funnelled into programs which are implementable in current policy settings and are targeted at delivery of transformational individual and systemic change.

Mental Health Australia and the National Mental Health Consumer and Carer Forum are uniquely placed to bring together a wide diversity of stakeholders across the Mental Health Sector to participate in future policy deliberations around psychosocial services. Both Mental Health Australia and the National Mental Health Consumer and Carer Forum look forward to working with Australian governments further on this important issue.

Please contact policy@mhaustralia.org for any further information.

End notes

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