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THE FUTURE HORIZON

Good Practice in Recovery-Oriented Psychosocial Disability Support

Stage Two Report

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Acknowledgement of Country

The research and project teams respectfully acknowledge the Wurundjeri people and the Boon Wurrung / Bunurong people of the Kulin Nation, who are the traditional custodians of the land where this report was created and pay our respect to their Elders past, present and emerging.

We recognise that Indigenous Australians have an ongoing connection to the land and value their unique contribution to La Trobe University, Mental Health Victoria, and the wider Australian society.

We recognise their lived experiences of colonisation and the strength and resilience of their living cultures and connection to Country. We embrace the spirit of reconciliation and commit to working towards community-driven and self-determining outcomes that ensure equality of outcomes and an equal voice.

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Executive Summary

Background

Mental Health Victoria (MHV) commissioned this project in order to meet a key deliverable of the National Disability Insurance Scheme (NDIS) Recovery Oriented Psychosocial Disability Support (ROPDS)– Growing National Workforce Capability Project.

The project has been conducted in two stages. Stage One led to *The Current Landscape* report which provides a summary of a literature review that focused on the history of recovery; recovery-oriented practice; the current practice environment; and key considerations for Stage Two of the Project.

This Stage Two report *The Future Horizon* provides information to guide the NDIS ROPDS Project team in developing a consistent national picture of the recovery-oriented capabilities required for psychosocial disability support workers. Stage Two has built on what was learned from the Stage One review and more directly explores how to address the barriers and workforce-related issues impacting on effective recovery-oriented practice for NDIS participants with psychosocial supports in their plans.

The background section of the report provides details regarding NDIS participants with psychosocial disability, how psychosocial disability has been defined, and what is known currently about who is accessing the scheme. The NDIS workforce is also described.

The aspirations for recovery-oriented practice explored in this document have been drawn from the leading practice perspectives and enablers within the NDIS context emerging from the Stage One research; it also incorporates capability frameworks, policy documents, recent innovations and both academic and grey literature. It explores the current opportunity in the NDIS context to further develop the recovery-orientation of the workforce.

Key Questions – What are we investigating?

- Looking ahead: Recommendations for what needs to change to achieve better ROPDS in NDIS service delivery
    - What is possible?
- What are the emerging and innovative ideas in the NDIS ROPDS sector?
- What are the key required workforce capabilities to deliver ROPDS?
- What are the workforce development needs to enable the delivery of ROPDS?

The project also aimed to include an analysis of organisational capabilities and approaches to build workforce capacity.

Method - What we did and how we did it.

The academic and grey literature, and other documentation used for this report, was initially identified from a series of searches using key words linked to each question. These search terms were entered into Google Scholar and Google to build on the comprehensive literature search undertaken and described in the Stage One Report, the *Current Landscape*. National policy documents and frameworks, and government and NDIS online resources, were able to be readily sourced using this method. Notably, the grey literature searches in Google were dominated by government websites and documentation. To further explore examples of innovative practice and resources that were not found through a systematic search process, the following strategies were employed:

- Drawing on industry knowledge from the research team including Mental Health Victoria staff.

- Exploring the resources and conference proceedings from the 2020 Mental Health and NDIS Conference.
- Undertaking consultations with Project Reference Group (PRG) members and other project stakeholders.
- Mental Health Victoria staff also provided findings from a survey with relevant stakeholders.

Recommendations for Recovery-Oriented Psychosocial Disability Support

To create recovery-oriented psychosocial disability support requires significant and lasting change in ways of working with people with psychosocial disability not only for the workforce but also cultural change in services.

In the short term, recommended changes to improve recovery-oriented psychosocial disability support involve:

- Developing recovery-oriented psychosocial support guidelines (see workforce and organisational capabilities).
- Supporting the use of NDIS recovery-oriented psychosocial support training packages or recommended training (see recovery-oriented practice training).
- Promoting coproduced peer led services, as well as fostering lived experience leadership, training, and support, drawing on lived experience perspectives (see Peer Work).
- Supporting leadership and cultural change in recovery-oriented psychosocial support (see organisational capability and building workforce capacity).

In the medium term, changes may include:

- Creation of psychosocial disability workforce standards.
- Credentialling and micro-credentialling training programs.
- Provision of support and supervision for psychosocial support workforce, including lived experience supervision.
- Further developing lived experience leadership and quality support, including career mobility for the peer workforce.
- Establishment of communities of practice for lived experience Recovery Coaches.

In the long term, ideal recovery-oriented service provision will include:

- Coproduced recovery-oriented services or organisations.
- Provider credentialling and organisational accreditation processes.
- Sector wide recovery-practice training.
- Endorsement of services as recovery-oriented by relevant peak bodies, a ‘Recovery-Oriented Tick-of-Approval’.

Recovery-Oriented Practice and Training

This report provides examples to illustrate good practice in recovery-oriented psychosocial disability support. These examples utilise different elements of recovery-oriented practice including addressing barriers and inequities in access to service provision, engaging the lived experience workforce to promote inclusion, coproduction, community participation, and social inclusion.

The key features of some potentially valuable practice development and recovery-oriented practice training opportunities also provide an overview of the potential resources to support the development of recovery-oriented practice for the NDIS workforce. These include recovery-oriented practice models supported by training that have been successfully trialled in Australia such as the Collaborative Recovery

Model and PULSAR and some training based on themes such as trauma informed practice and cultural safety, and also consumer led training such as Intentional Peer Support (IPS), Wellness and Recovery Action Planning (WRAP) and Emotional CPR.

Peer work – A contemporary example of workforce development

The report identifies parallels between the peer workforce and the emerging NDIS workforce to illustrate some of the common struggles that they face as emerging workforces in supporting people with psychosocial disability. The competencies outlined in the Cert IV in Mental Health Peer Work and Intentional Peer Support (IPS) training may often be relevant and applicable to workforces beyond the peer workforce, including the NDIS workforce.

Recovery Oriented Psychosocial Disability Workforce Capabilities

This section outlines the key workforce capabilities required to deliver recovery-oriented psychosocial disability support. Capabilities are typically defined as encompassing a number of the values, knowledge, attitudes and behaviours, skills and abilities, and may be organised within a number of themes or domains. Capabilities for recovery-oriented practice and service delivery then refer to the values, knowledge, attitudes and behaviours, skills and abilities that enable workers to support people experiencing mental health conditions to live a life that is self-defined, self-determined, meaningful, and satisfying (Department of Health and Human Services, 2020). Recovery-oriented capabilities can be used as a framework to assist workers, and more broadly the workforce, to incorporate and shift practices to be recovery focused.

The Recovery Oriented Psychosocial Disability Workforce Capabilities are categorised here in four specific domains, although there is significant overlap and they should not be viewed as discrete.

The domains identified and discussed are:

1. Person-Centred (Person-centred, person-led, and person 1st).
2. Supporting personal recovery.
3. Social inclusion and social determinants.
4. Care coordination and collaboration.

The knowledge base, values and attitudes, skills and measurable indicators for each of these domains is then outlined.

Organisational Capabilities

Extending from the Recovery Oriented Psychosocial Disability Workforce Capabilities that outline the capabilities and enablers at a worker level, organisational capabilities and building workforce capacity focus on the broader systems and processes for delivering recovery-oriented psychosocial disability support. Building workforce capacity focuses on the process for organisational change to a recovery-oriented approach and increasing the skills and training of the workforce.

The organisational capability domains identified and discussed are:

1. Organisational Systems and Processes.
2. Organisational Values and Culture.
3. Organisational Networks and Community.
4. Quality Improvement.

The knowledge base, values and mission and skills and measurable indicators for each of these domains is then further detailed.

Building Workforce Capacity

Introducing recovery-oriented practice requires organisational implementation strategies to overcome barriers to change. This report provides an integrated summary of the various challenges identified and how these may be overcome. The role of networks and Communities of Practice in building workforce capacity is discussed.

Finally, research and evaluation activities are an important factor in developing the ongoing evidence base for practices, models and programs – and to drive quality improvement in the sector.

Conclusion

This report explores how to address the barriers and workforce-related issues impacting on effective recovery-oriented practice for NDIS participants with psychosocial disability. It identifies the potential benefits and challenges associated with developing the workforce capabilities for recovery-oriented practice, as well as the organisational capabilities for supporting recovery-oriented practice and the measurable indicators necessary to evaluate their achievement both among workers and at an organisational level. It is hoped that this work will contribute to guiding the development of a consistent national picture of the recovery-oriented capabilities required for psychosocial disability support workers.

Background

Rationale

Mental Health Victoria (MHV) commissioned this project in order to meet a key deliverable of the National Disability Insurance Scheme (NDIS) Recovery Oriented Psychosocial Disability Support (ROPDS)– Growing National Workforce Capability Project. The focus of this report is to outline best practice in recovery-oriented psychosocial support, provide guidance for improving the National Disability Insurance Scheme (NDIS) psychosocial workforce capacity in recovery-oriented practice, and outline the capabilities for enabling recovery-oriented practice in the NDIS context. The report is targeted to the NDIS workforce, governing bodies, organisations, peak bodies, and individual workers. However, the primary aim is to promote the interests of people with psychosocial disability and their families who are participants of the NDIS.

Key issues related to NDIS service delivery that have been considered are:

- Lived Experience perspectives about Recovery Oriented Practice
- Recovery and NDIS participants with psychosocial support needs including those:
    - Who have a dual diagnosis, a dual disability, or who have complex support needs.
    - Who are from Aboriginal and Torres Strait Islander communities.
    - Who are from Culturally and Linguistically Diverse (CALD) backgrounds.
    - Who are from LGBTIQ+ identity groups.

The findings of this project will assist the NDIS ROPDS project team to develop other aspects of the Project, which include guides to Good Practice and audits of current ROPDS professional development products and programs, capacity building activities and core competencies and approaches to expand the NDIS workforce capacity.

The project has been conducted in two stages. Stage One led to *The Current Landscape* report which provides a summary of a literature review that focused on the history of recovery; recovery-oriented practice; the current practice environment, and key considerations for Stage Two of the Project.

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- Drawing on industry knowledge from the research team including Mental Health Victoria staff.
- Exploring the resources and conference proceedings from the 2020 Mental Health and NDIS Conference.
- Undertaking consultations with PRG members and other project stakeholders.
- Drawing on findings from a survey with relevant stakeholders also provided by Mental Health Victoria staff.

Terminology

A note about the terminology used in this report. Terms have been selected with care to convey respect for the people and groups who are referenced in this report. In the report the terminology used is preferred by the NDIS or the Project Reference Group (PRG). Notably, many terms can have multiple definitions or meaning depending on their origins and contexts of use. Academic disciplines, stakeholder groups and governing bodies use different terminology over time. The preferred terminology, particularly for specific concepts has been selected with reference to the literature where it may differ from the preferred terms. The Stage One report *The Current Landscape* provides more detail about and further discussion of these terms and concepts. See also the Glossary of key terms for definitions and abbreviations for terminology used in this report.

NDIS Participants with a Psychosocial Disability

In the NDIS, psychosocial supports can be provided to people who have a psychosocial disability as their primary disability or as a secondary disability. Additionally, people with a disability who have mental health conditions may experience impacts to their wellbeing or find their disability is affected by their mental health condition. Notably, the NDIS focuses on the way that a person's mental health condition impacts their ability to participate in daily life, and a diagnosed mental health condition is not required to access the NDIS (NDIS, 2018). In addition to psychosocial disability, the impacts of co-occurring health conditions on a person's ability to participate in daily life are also considered by the NDIS.

Psychosocial Disability Support Needs

Psychosocial disability has been defined by the National Mental Health Consumer & Carer Forum (2011, p. 16) as "the disability experience of people with impairments and participation restrictions related to mental health conditions". The NDIS focuses on the way that a person's mental health condition and other co-occurring health conditions impact their ability to participate in daily life, as opposed to focusing on clinical diagnoses and treatment (NDIS, 2018).

People with psychosocial disability may experience challenges with the following elements: environmental stimuli, concentration, stamina, time pressures and multiple tasks, interacting with others, feedback and stress (National Mental Health Consumer & Carer Forum, 2011). The NDIS provides psychosocial supports where participants experience reduced functioning or impairment and participation restrictions related to the following activities: communication, social interaction, learning, mobility, self-care, self-management, and social and economic participation (O'Halloran, 2015, p. 16).

Within the NDIS, psychosocial disability may be classified by severity and impact on the person's life. In this context, terminology such as 'profound and severe' may be used to describe the impact of a person's psychosocial disability that may have intensive or complex support needs. However, this may be problematic since many mental health conditions can be episodic or have fluctuations in severity, symptoms and impact, meaning their experience of psychosocial disability can also fluctuate over time (National Mental Health Consumer & Carer Forum, 2011).

Psychosocial Disability Data

In Australia, the Productivity Commission has estimated that 690,000 people may benefit from psychosocial supports and of that group, 290,000 people are described as having a severe and persistent mental illness (Productivity Commission, 2020, p. 42). These figures contrast with the reported numbers of people receiving psychosocial supports from the NDIS at 40,512, and from State, Territory and Federal Government programs at 75,000 (NDIS, 2020e; Productivity Commission, 2020). As a proportion of the Australian population, this is further illustrated in Figure 1:

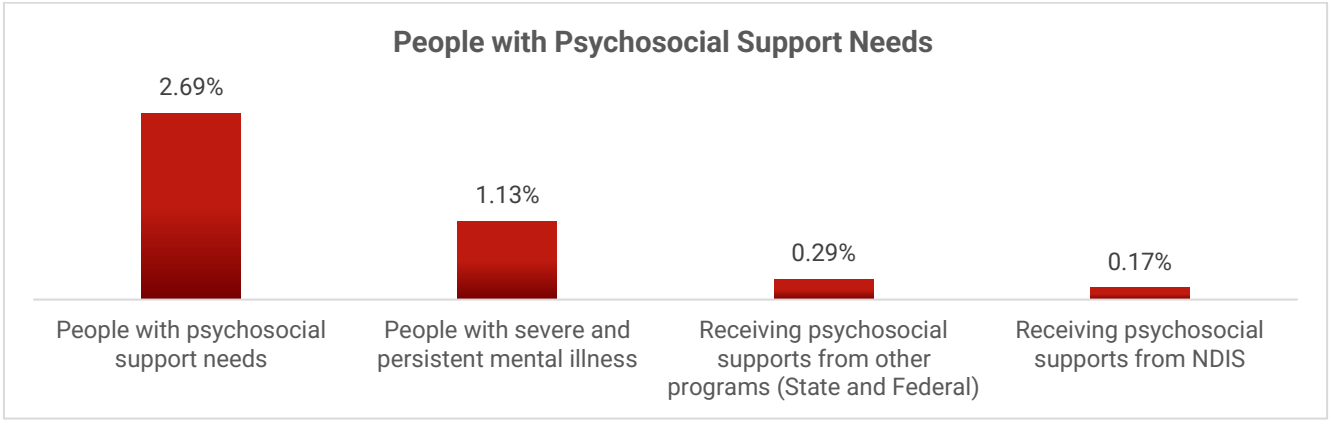

FIGURE 1: PSYCHOSOCIAL SUPPORTS AS A PERCENTAGE OF TOTAL AUSTRALIAN POPULATION.

For the wider population of people with mental health conditions, unfortunately there is a significant gap in people who are eligible for the Scheme and those who access it. For example, St Vincent`s Mental Health (2019) in Victoria reported that for the consumers of their service who were eligible for NDIS supports, only 50 percent accessed the scheme, and that of that group a further 50 percent had plans that failed. Notably, the NDIS has since introduced several changes to address this gap, to improve plan utilisation and increase flexibility.

NDIS Participant Data

As reported by the NDIA in 2020, there were 40,512 NDIS participants with a primary psychosocial disability, or approximately 10 percent of people with a primary psychosocial disability (NDIS, 2020e). Notably, there are differences in the reported number of participants within the materials published from the NDIS. These differences arise due to factors such as people who have been accepted to the Scheme but are awaiting a plan, the use of estimates from the Productivity Commission, changes in participant numbers over time (people entering and exiting the scheme), and the use of statistical analysis from other surveys to analyse NDIS data. Where possible, the most current figures have been used.

The number of NDIS participants with a psychosocial disability is lower than projected. The Productivity Commission estimated that there would be 65,000 or 13.8 percent of participants with a psychosocial disability in the scheme once the rollout is completed (Productivity Commission, 2020). Where gender is known, 55 percent of NDIS participants with a psychosocial disability are male, and 45 percent female (NDIS, 2019b, p. 14). Figure 2 shows the percentage of NDIS participants with a primary psychosocial disability by state, excluding South Australia and Tasmania due to aged-based phasing (NDIS, 2019c):

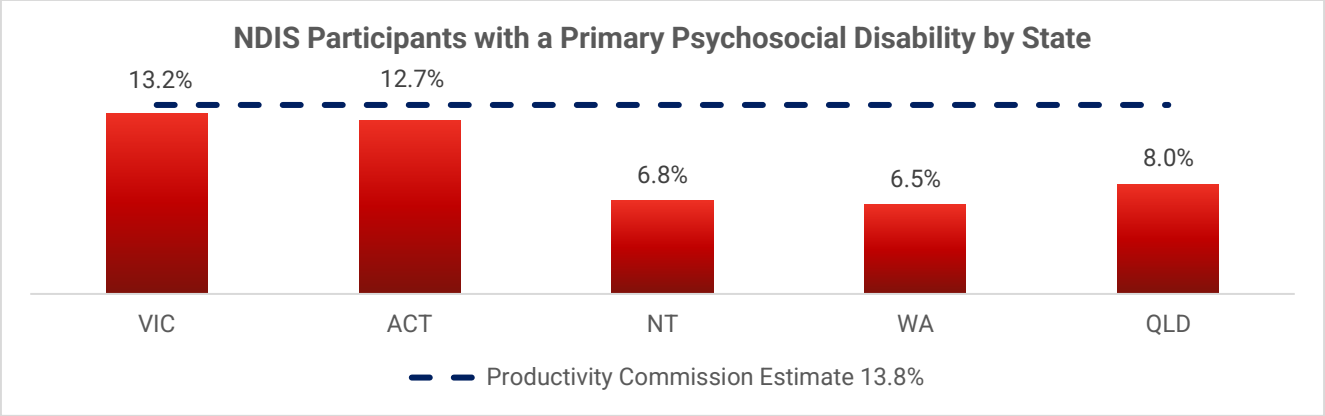

FIGURE 2: NDIS PARTICIPANTS WITH A PRIMARY PSYCHOSOCIAL DISABILITY BY STATE AS A PERCENTAGE OF TOTAL NDIS PARTICIPANTS (NDIS, 2019C).

Notably, psychosocial supports may be provided by the NDIS for people with a primary or secondary psychosocial disability. This is reflected in Figure 3, which shows the number of participants receiving psychosocial supports inclusive of people with a primary psychosocial disability.

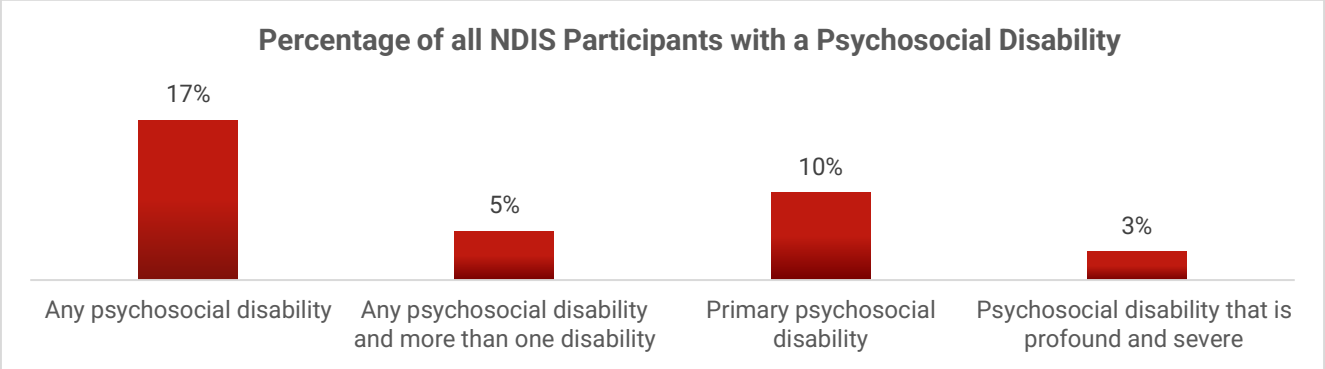

FIGURE 3: NDIS PARTICIPANTS WITH A PSYCHOSOCIAL DISABILITY, PERCENTAGE OF TOTAL NDIS POPULATION.

Key Population Groups

NDIS analysis, utilising data from the Survey of Disability and Aged Care, estimates that three percent (approximately 1200 people) of NDIS participants with a psychosocial disability have a profound and severe disability (NDIS, 2019b, p. 15) (see figure 3). Of this group, 66 percent are female, and 33 percent male (NDIS, 2019b, p. 15). Of the other key population groups identified in this report, the NDIS reports figures for participants from CALD backgrounds, and for participants from Aboriginal and Torres Strait Islander communities (NDIS, 2019a, 2019b) (see Figure 4).

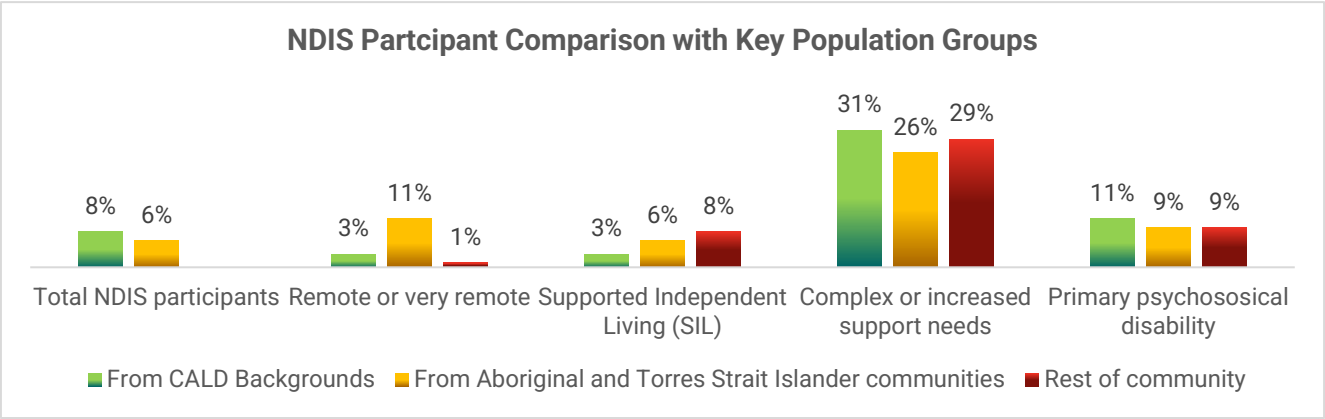

FIGURE 4: NDIS PARTICIPANTS FROM CALD BACKGROUNDS AND FROM INDIGENOUS COMMUNITIES (NDIS, 2019A, 2019B).

Notably there is no data for LGBTIQ+ participants of the NDIS. In the LGBTIQA+ Strategy the NDIS (2020c, pp. 7-8) explores this issue, stating: "we are committed to improving the NDIA's systems and processes for the collection, monitoring and evaluation of relevant data to address this issue, noting that structured data will take time to define, capture, and analyse" (pp. 7-8).

Age

The NDIS currently provides supports to people with a psychosocial disability across all age groups (Figure 5). The majority of NDIS participants receiving psychosocial supports are aged between 45 to 54 years old, closely followed by people aged 55 to 64 years and 35 - 44 years. Age-related considerations are therefore important in regard to the perspectives of recovery in this population, and the NDIS workforce needed to provide psychosocial disability support.

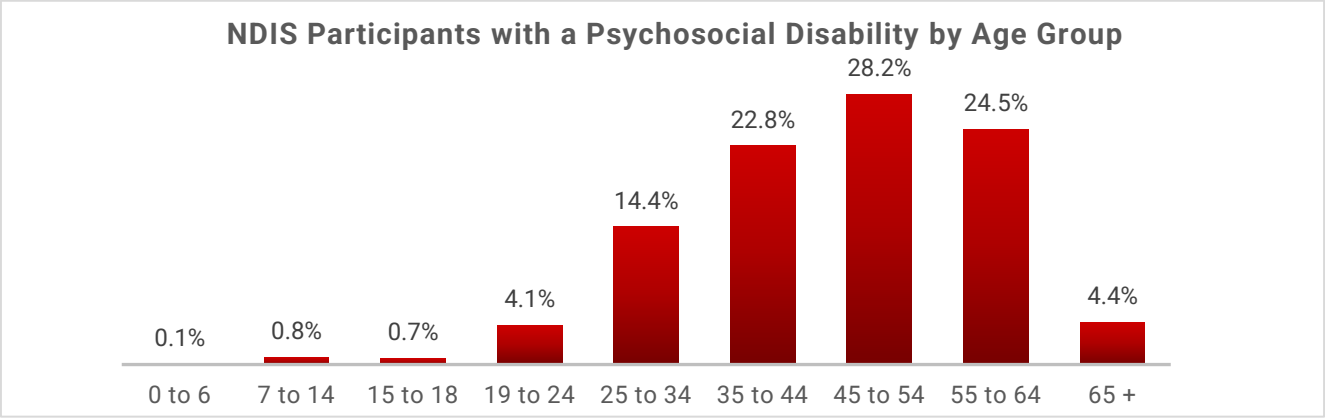

FIGURE 5: PERCENTAGE OF TOTAL NDIS PARTICIPANTS WITH A PSYCHOSOCIAL DISABILITY, BY AGE GROUP.

There are also limitations in the above snapshot age profiles of NDIS participants with a psychosocial disability due to several factors such as the current eligibility requirements of the NDIS. As reflected in

the NDIS data, very few young people are considered to have long term or permanent psychosocial disability and are therefore not able to access the scheme (Orygen, 2019). As Hayes et al. (2018) argue, early intervention measures for people with a psychosocial disability offer the opportunity to alleviate functional loss and build capacity for meaningful participation in society. Despite this, few people over the age of 18 are able to access early interventions, particularly for psychosocial support (Hayes et al., 2018; Orygen, 2019).

In their review, Hayes et al. (2018) identified several evidence-based supports that align with the goal of early intervention in the NDIS for people with psychosocial disability, including supported employment, supported housing and social skills training. In addition, these supports are designed to be individualised, to promote personal choice, pursuit of self-chosen goals and to promote recovery (Hayes et al., 2018). As they state "the identified supports have the potential to offer significant gains in people's capacity to participate when applied early in their experience of psychosocial disability, or early in their NDIS plans, so should be routinely considered during NDIS planning" (Hayes et al., 2018, p. 580).

Plan Utilisation and Budget

Plan utilisation figures show that on average only 62 percent of individual plan budgets are used, of an average budget of $77,000 (NDIS, 2020e). These figures may indicate some of the workforce challenges for the growing NDIS market, including limited provider capacity, thin markets, challenges with participant engagement, and a lack of clarity and communication to support client led and meaningful plans. Addressing such challenges will be essential to make recovery-oriented psychosocial disability support a reality for NDIS participants.

NDIS Workforce

Understanding the workforce that provides the support and services delivered for NDIS participants with a psychosocial disability is important before providing a detailed exploration of recovery-oriented practice. Broadly and simply the NDIS workforce refers to those individuals and organisations that provide support and services to those accessing the NDIS. Illustrative of how broad the spectrum of the workforce is, the NDIS Quality and Safeguards Commission (NDIS Commission) states a worker is anyone who is employed or otherwise engaged to provide NDIS supports and services to people with disability (The NDIS Quality and Safeguards Commission, 2021).

The NDIS workforce consists of workers who are paid and unpaid, volunteers, self-employed, employees, contractors, and consultants (The NDIS Quality and Safeguards Commission, 2021). The workforce therefore covers a wide spectrum of workers with various roles, qualifications, and level of interaction with participants. These roles can include working directly in frontline positions assisting with personal care, working in homes and community settings; they also include roles in which a lived experience perspective is central, and roles that require qualifications in specialised areas to assist and support participants to achieve their goals and aspirations (Department of Health and Human Services, 2018).

Figure 3 describes the NDIS workforce. For the vast majority of NDIS participants, other providers across various sectors are often also involved, such as General Practitioners (GPs), clinical mental health services, and disability employment services. Hence diverse supports not only across multiple services, sectors and systems may be involved in addressing experiences of wide-ranging needs for treatment, care and support in promoting recovery, but also informal and community networks (see Figure 7, next page).

NDIS Workforce Spectrum

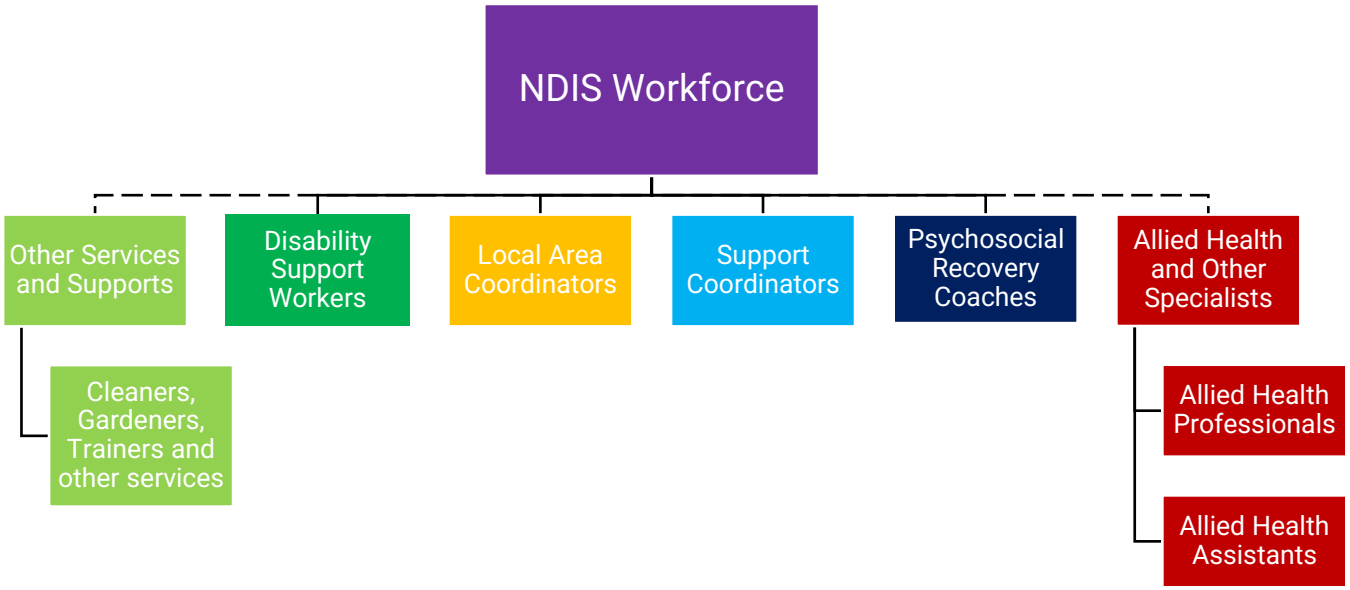

FIGURE 6: NDIS WORKFORCE CHART

Figure 1: Groups involved in a person's recovery

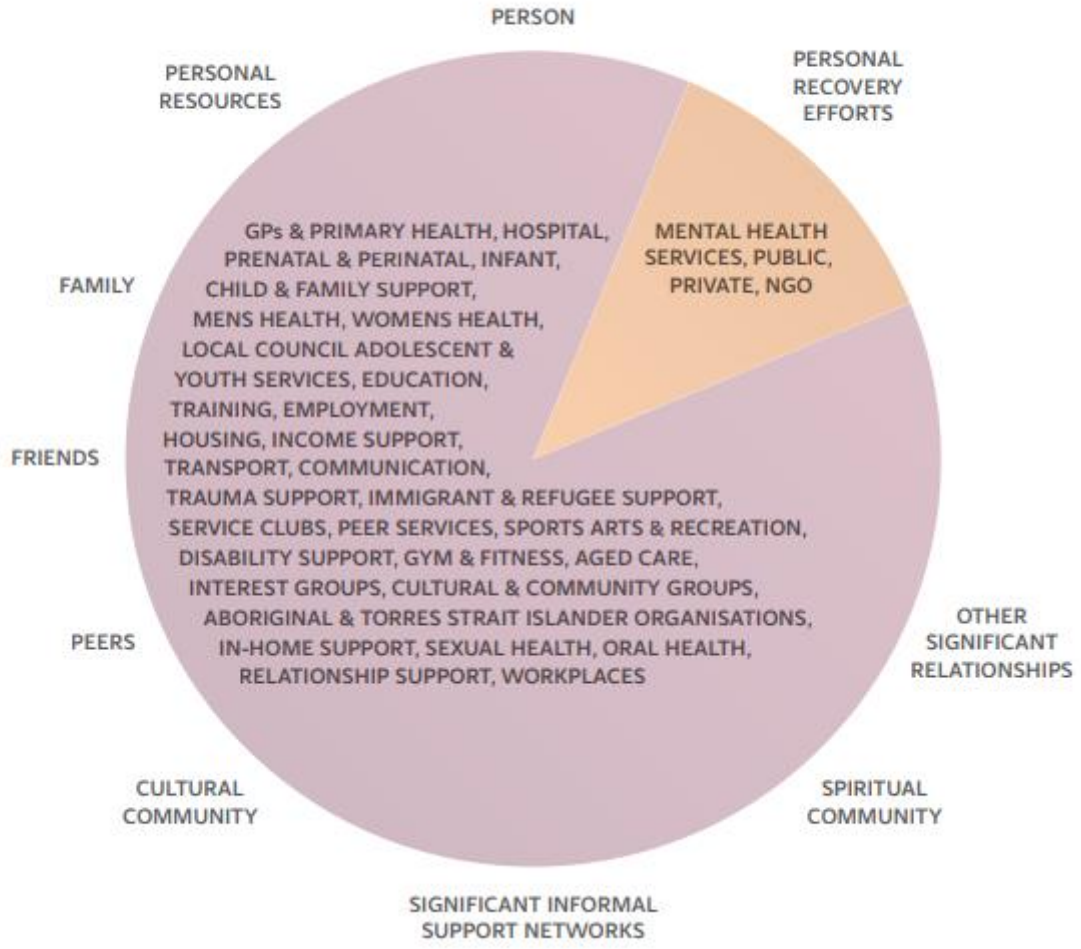

FIGURE 7: RECOVERY NETWORKS OUTSIDE MENTAL HEALTH AND PSYCHOSOCIAL DISABILITY SERVICES (Australian Government Department of Health, 2013b).

NDIS Psychosocial Disability Support Roles

This report focuses attention onto specific roles of the NDIS workforce directly related to providing psychosocial disability support within this broad workforce spectrum. The roles of focus for this report include: Disability Support Workers, Support Coordinators, Local Area Coordinators (LAC), and Psychosocial Recovery Coaches (Recovery Coach). However, the recovery oriented capabilities described in this report may also be relevant to others involved in providing support to NDIS participants including allied health professionals and those providing practical assistance such as cleaning and personal care.

Disability Support Workers

The role of NDIS Disability Support Workers is to support and assist participants in numerous ways to reach their goals and live their lives. The Support Workers' role can include providing direct support such as assistance with daily personal activities, community support, social support, and inclusion (The Salt Foundation, 2021). Working in this role can involve, among other tasks, supporting independent daily living skills, personal activities of daily living, participation in recreational and social activities, and assistance with travel and transport (Department of Social Services, n.d.; The Salt Foundation, 2021). A participant's NDIS plan can cover Support Workers to support and assist in the above listed areas.

Support Coordinators

Support Coordinators is the role title for those who provide support coordination to participants with an NDIS plan. The main goal of Support Coordinators is to assist participants to utilise their plan in the most optimal manner in order to achieve their goals. A Support Coordinator can assist participants to negotiate with providers about what services they can provide and at what cost as well as ensuring service agreements and service bookings are completed (NDIS, 2021c). This role is set out to assist participants in building their ability to exercise choice and control, to coordinate supports, and access their local community. There are three levels of support coordination currently on offer: support connection; support coordination; and specialist support coordination. Support connection is concerned with building a participant's ability to connect with informal, community, and funded supports. The support coordination level is concerned with assisting participants to build their skills needed to understand, implement, and use their plans. At this level they seek to ensure there is a mixture of supports across a number of areas required in order for participants to reach their goals. Finally, the highest level is specialist support coordination, which is a support item included in participants' plans where there are situations requiring more complex and specialist support coordination, usually only for short-term periods until the situation resolves Support Coordinators are funded through a participant's plan to provide one of these levels of support coordination, and those registered to provide this assistance in each state are published regularly by the NDIA.

Local Area Coordinators

Local Area Coordinators (LACs) provide support to participants and plan nominees at multiple stages of the NDIS process. They provide support to understand, navigate, and access the NDIS, and then assist to create, implement and review the NDIS plan (NDIS, 2020b). Local Area Coordinators (LACs) may assist participants in locating and connecting with support coordination providers (Brotherhood of St Laurence, 2017). Once an individual has an approved plan and becomes a NDIS participant the LAC will also support them to implement their plan. The role of a LAC is to support a participant to understand the plan and help them to connect with service providers in their area.

Psychosocial Recovery Coach

The Psychosocial Recovery Coach role (Recovery Coach) is an important and relatively new NDIS support role (NDIS, 2020). Recovery Coaches may include individuals with lived experience and those with learned experience. Recovery Coaches assist NDIS participants to find different services and supports that may assist them to live a purposeful and meaningful life as defined by them.

Eligible participants may be funded to access the support of a Recovery Coach. This will typically involve discussions with the participant about their life, needs and aspirations, and could also involve conversations with family, friends and other supporters who are important in the participant's life. Participants who have the corresponding funding may employ both Support Coordinators and Recovery Coaches, however, it is recommended to only have one, not both. LACs can consult with participants about whether to choose a Recovery Coach and/or Support Coordinator including details regarding the number of hours needed and the associated costs.

Allied Health and Other Specialists

Other service providers, such as Allied health assistants, Allied health professionals, and other specialists, can also be important in assisting and supporting NDIS participants to live a self-determined and fulfilling life. This group of workers also form part, although a smaller percentage, of the workforce providing support and assistance to NDIS participants (Department of Health and Human Services, 2018; Snell et al., 2018). This group includes allied health professionals and those workers who utilise their professional skillsets, and knowledge gained from formal qualifications and experience. Included in this group are psychologists, speech pathologists, occupational therapists, and social workers. These

workers assist in providing capacity building supports to enable NDIS participants' social and community participation, as well as providing evidence, assessments, and reports that are utilised to inform access and planning decisions (NDIS, 2021a). Currently in the pilot phase, Independent Assessor roles will be available to allied health professionals (see Independent Assessments).

Other Services and Supports

Non-disability specific services and supports can be provided through the NDIS, these may include services such as cleaning, gardening, personal training, hairdressing, and other professionals. Notably, disability support workers may occasionally deliver some of these services.

Independent Assessments

In 2020 the NDIS introduced the Independent Assessment Framework to outline the scope, process, and reasoning for the changes, as part of the planned changes to the NDIS. Currently in a pilot phase, independent assessments are intended to introduce a free and independent assessment process for access to the NDIS and for ongoing NDIS plan reviews. As the NDIS describes the Independent Assessment process, it is intended to improve NDIS decision making to become more "equitable, valid and consistent" (NDIS, 2020a, p. 21). The Independent Assessment process assesses functional capacity through the use of Independent Assessors who interview participants and utilise standardised assessment tools and measurement scales.

The planned introduction of Independent Assessment has received significant feedback from participants, advocates, peak bodies, other stakeholders and the media. As VMIAC (2020) describes, the concerns about the introduction of Independent Assessments include not enough consultation with people with disability, the potential impact on choice and control, potential harms from the process, that the process is not fit-for-purpose, concerns about re-assessing participants without good cause, and creating disengagement and potential deterrents to accessing the NDIS. The planned rollout of Independent Assessment is currently under review by the Minister for the NDIS, with announcements expected later in 2021 (Department of Social Services, 2021).

Personalised Plan Budgets and Plan Flexibility

Currently a shift towards increased personalised plan budgets and flexibility is planned to come into effect starting late 2021 (National Disability Insurance Scheme, 2021). Previously, plans were funded based on individual items or supports, including some of the roles listed above (i.e., Support Workers, Support Coordinators, and Recovery Coaches). Going forward, a budget might be closely matched to a participant's functional capacity and the impact of their environment. It is hoped that these changes will make plans simpler and easier to use for participants. Under these proposed changes, there will no longer be core, capacity building, and capital budgets. Instead, there would be just two categories: a fixed budget for specific supports such as high-cost assistive technology, specialist disability accommodation, or home modifications; and a remaining budget that is flexible to ensure participants are supported in ways that enable them to pursue their goals. The funds in participants' flexible budgets will be released at regular intervals, with the goal of assisting participants to use their plans to purchase supports to meet their needs in a manner that best suits them (National Disability Insurance Scheme, 2021).

Price Control Arrangements

When discussing participants' plan budgets, roles, choice and control, the influence of pricing categories for supports is important to note. From February 2019 three levels of price controls have been bought into effect. These price control arrangements are for providers delivering assistance with self-care activities (one-to-one) and assistance to access community, social, and recreational activities (one-to-one) (NDIS, 2021b). The three levels of price controls are:

- Level 1 – for standard supports.

- Level 2 – for high intensity supports.
- Level 3 – for very high intensity supports.

These price controls are not directly linked to the complexity of a person's disability and its impacts, rather they are linked to the skill level of the worker who delivers the support. Further, these price controls are directly aligned to the Social, Community, Home Care and Disability Industry Award 2010 (SCHADS Award). The introduction of these levels has been influenced by the NDIA's recognition after consultation with the sector that a higher skilled and experienced worker may be required to work with participants with high intensity physical support needs or complex support needs (NDIS, n.d.).

Workforce Qualifications

Within the previously outlined broad spectrum of the NDIS workforce supporting NDIS participants with psychosocial disability, there is great variability in terms of the work performed, skills required, and qualifications held. Disability support workers providing direct support such as assisting with personal care, general living skills and community participation can correspond to Direct Service Delivery (DSD) roles level 1 to level 3. As Snell et al. (2018) describe, this group of disability support workers are the majority of employees in the sector and are likely to be recruited to positions at levels 2 and 3 of the SCHADS Award. It should be noted that those workers in roles that correspond to level 1 of the SCHADS Award (the DSD level 1) may in many cases be initial recruits or employees who are going through on-the-job-training (Snell et al., 2018). Other qualifications of DSD roles at level 1, 2 or 3, may include Certificate II, III or IV in Disability or other related certificates, some roles at this level are engaged as traineeship programs.

There is continuing expansion of the sector and a rapidly changing policy and regulatory environment, leading to the challenge of not being able to keep up with the market demand for appropriately skilled workers. The increasing casualisation of workers in the industry has also played a role in the challenges associated with ensuring disability support workers have the necessary skills and qualifications to appropriately support participants. Illustrative of the attention this area of workforce qualifications has received, and continues to receive, is priority 4 of Victoria's Workforce Plan for the NDIS, which is concerned with targeting quality training and reviewing the current disability-related training qualifications in the state (State Government of Victoria, 2021b). For more information about training for peer work see the section below where peer work training and education is discussed in more detail.

NDIS Workforce Size, Composition, Employment Profile, and Future Growth Needs

There is currently a lack of reliable workforce data around the size and composition of the workforce of interest to this report (Commonwealth of Australia, 2020). Key estimates include the Department of Social Services (DSS) 2019 figure of approximately 138 000 full-time equivalent workers (FTE) in the NDIS workforce. However, this number also accounts for workers that are outside the focus of this report but who perform a variety of roles which are essential to the overall operation of the scheme. The other key estimate of the size of the workforce regularly referred to is the DSS Growing the NDIS Market and Workforce Strategy, which indicates there are approximately 100 000 FTE workers in the sector.

There is a lack of comprehensive data around not only the size but also the specific composition. Current information around the disability workforce indicates that nationally it comprises predominately women and is aged over 45 (Australian Government Department of Social Services, 2019; National Disability Services, 2019). In 2018 the NDS National Disability Workforce Report estimated that 70% of disability support workers were women, and over 44% of workers were aged over 45 years (National Disability Services, 2018).

The NDIS Demand Map is a recent data analytics tool that seeks to provide forecast information around how many workers may be required to meet NDIS participants needs and preferences. It should be noted

there is no specific data on the number of workers who make up the workforce of the NDIS. Without this information forecast estimates of the workforce needed in the future is calculated by the analysis of participant spending, using assumptions informed by stakeholder interviews on the share of NDIS payments paid as labour costs. The NDIS Demand Map provides estimates for several occupation groups however, there are some with low forecast numbers and/or uncertainty that have been combined into the “other” category. Subsequently, this impacts the forecast estimates for occupations such as social workers, nurses, podiatrists, human resource managers, nutrition professionals, manufacturers, and fitness instructors.

Aspirations for Recovery-Oriented Practice

In *the Current Landscape* report, recovery-oriented practice has been conceptualised through multiple perspectives and then the enablers of recovery-oriented practice were explored.

The aspirations for recovery-oriented practice explored in this document have been drawn from the leading practice perspectives and enablers within the NDIS context emerging from the Stage One research. Also included are capability frameworks, policy documents, recent innovations and other academic and grey literature. It explores the current opportunity in the NDIS context to further develop the recovery-orientation of the workforce (see methods section).

The aspirations for recovery-oriented practice are informed by current evidence, lived experience and industry perspectives. This sets the benchmarks to guide improvements in recovery-oriented psychosocial disability support.

Recovery-oriented psychosocial disability support

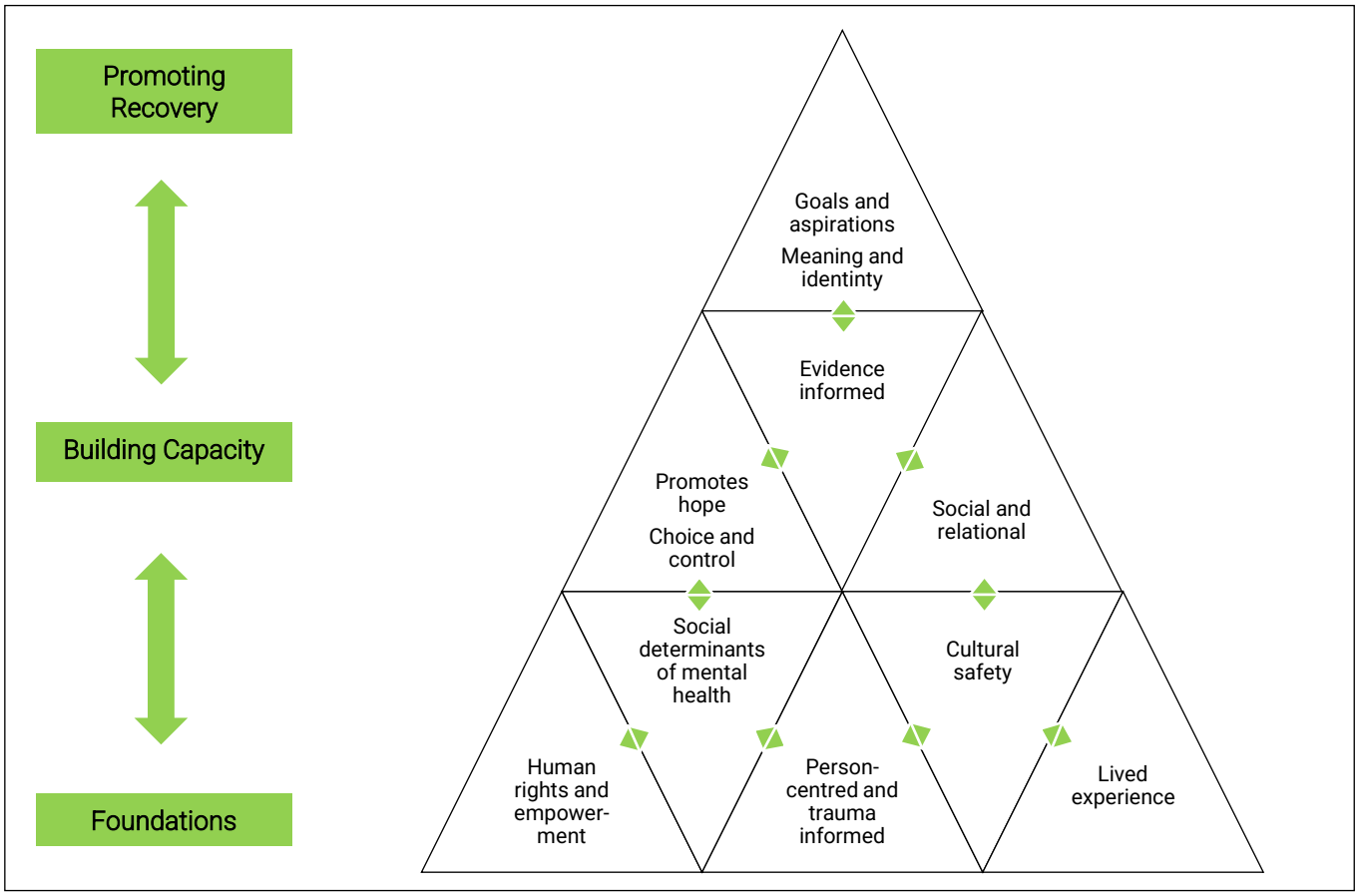

FIGURE 8: INTERSECTING ELEMENTS OF RECOVERY-ORIENTED PRACTICE

Recovery-oriented practice

The elements described in Figure 8 outline foundational values and principles for recovery-oriented practice that guide capacity building and supporting personal recovery. Recovery-oriented practice reflects and acknowledges the inherent rights and dignity of each NDIS participant and their families.

There is a current opportunity in the NDIS context to further develop the recovery-orientation of the NDIS workforce by focusing on these elements:

- Social determinants of mental health.
  - Understanding the social determinants of mental health and its impacts on wellbeing.
  - Impact of stigma and discrimination, intersectional disadvantage, and marginalisation.
  - Barriers to participation, access, inclusion, and recovery.
  - Social model of disability.
- Human rights and empowerment.
  - Challenging low expectations for people with psychosocial disability and stigmatising views of mental illness.
  - Promoting citizenship and participation.
  - Supported decision making.
- Trauma informed.
  - Recognising the impact of trauma on mental health and the body.
  - Trauma relating to services use.
  - Trauma from personal history.
  - Intergenerational trauma.
  - Trauma experienced by family and carers.
- Person-centred.
  - Driven by the individual needs, goals, and experience of life.
- Cultural safety.
  - Grounded in practices that demonstrate an appreciation and respect for peoples cultural and linguistic needs (including the Aboriginal and Torres Strait Islander peoples and CALD communities).
  - Understandings of distress and mental health in culturally diverse communities.
  - Consider the different meanings of 'recovery' across cultures.
- Lived experience.
  - Engages with people who have lived experience including services users, peer workers and other lived experience experts.
  - Embeds lived experience roles throughout the mental health system, including leadership and decision-making roles.
  - Codesigned and coproduced programs, services, research, and policy.
  - Emergence of participant-led organisations and services.

As represented by the CHIME framework (Leamy et al., 2011), connectedness, hope, identity, meaning and empowerment sit at the centre of recovery. Recovery-oriented practice promotes these elements, holding hope, empowering the person and their families, connecting the person to community, and supporting the formation of identity and meaning in their recovery journey.

Furthermore, current opportunities to develop recovery-oriented psychosocial disability support are consistent with best practice and contemporary frameworks in disability practice, in areas such as promoting hope, choice and control, a person-centred approach and the central importance of engaged, trusting and respectful working relationships.

It is important to note that cultural safety has been highlighted as a key barrier for Aboriginal and Torres Strait Islander communities to access and utilise NDIS plans. As the Victorian Aboriginal Community

Controlled Health Organisation (2020) describe in their submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability:

> an 'ordinary life' for an Aboriginal person includes Culture, Community and family-based culturally safe services which are not currently supported through the individual- focussed NDIS system. To further exacerbate the issue, there has been insufficient priority placed on cultural safety training by the NDIA and lack of collaboration with Aboriginal communities to tailor and improve either the system design or service delivery by mainstream providers (p. 2).

Furthermore, the key pillars of social and emotional wellbeing, Culture, Country, spirituality, community and belonging, are crucial to the successful recovery of people from Aboriginal and Torres Strait Islander Communities (Dudgeon et al., 2017).

Building the Social and Relational

Relationships are central to recovery-oriented psychosocial disability support. Not only the relationship between the worker and the participant, but also relationships with their family, carers, friends, and other supporters, facilitating connection to community, and relationships between services.

The Royal Commission into Victoria's Mental Health System (State of Victoria, 2021b) identified limitations in individualistic approaches to supporting people with mental health conditions. As they state, "this individualised approach means that the valuable role families, carers, and support networks can play in a consumer's recovery is often overlooked by services, as is the notion that families, carers and supporters have needs in their own right" (State of Victoria, 2021b, p. 72).

The limitations of individualistic approaches also impact participants from Aboriginal and Torres Strait Islander communities. As noted by the Victorian Aboriginal Community Controlled Health Organisation (2019) in response to the draft principals from the Psychosocial Disability Recovery-Oriented Framework:

> "The NDIS emphasis on agency may be too heavily focused on western understandings of personhood, and therefore not capture the significance of individual recovery in the context of family and the broader community" (p. 2).

The Practical guide for working with carers of people with a mental illness (Mind Australia & Helping Minds, 2016, p. 11) outlines six strategies for working in partnership with carers:

1. Carers and the essential role they play are identified at first contact, or as soon as possible thereafter.
2. Staff are carer aware and trained in carer engagement strategies.
3. Policy and practice protocols regarding confidentiality and sharing of information are in place.
4. Defined staff positions are allocated for carers in all service settings.
5. A carer introduction to the service and staff is available, with a relevant range of information across the care settings.
6. A range of carer support services is available.

As noted by Mental Health Carers Australia (2021) some families and carers can experience significant impacts where NDIS plans do not adequately reflect the needs of the participant. Three leading challenges in the NDIS planning process can arise where; the planner is not knowledgeable about psychosocial disability and mental health; families are carers are not adequately included in the planning process; or fear that packages will be smaller if there is strong 'informal support' (Mental Health Carers Australia, 2021). The resulting impacts can be significant including significant stress to the participant and their families and carers, the needs of families not met, and families and carers needing to meet the gap in plans often by having to leave or downgrade their employment (Mental Health Carers Australia, 2021).

Enhancing Choice and Control

One of the guiding premises of the NDIS and other personalisation models is in providing choice and control to people with a disability. The provision of meaningful choice and control is vital to enabling self-determination and autonomy (Davidson et al., 2017). Notably, to facilitate a recovery-oriented approach, the provision of choice through the NDIS should reflect the promotion of self-determination. In their research, Wilson et al. (2021) explores the barriers to choice for people with a psychosocial disability who are participants of the NDIS. This research highlights some of the challenges that people with psychosocial disability experience in exercising choice and decision making in the NDIS. The barriers to choice at each stage of the decision making process in the NDIS were:

- Personal, as a result of negative service history, symptoms, trauma, and disempowerment.
- Programmatic, such as a lack of information, poor sector navigation, complex or lengthy NDIS processes.
- Market based, where there were thin markets or insufficient availability of services

(Wilson et al., 2021).

The research highlighted the importance of high-quality support coordination. Support coordinators that were knowledgeable about mental health and services available through the NDIS, that could also engage in supported decision making, assisted participants to overcome the barriers to choice and subsequently more likely to have successful plans (Wilson et al., 2021).

Recommendations for Recovery-Oriented Psychosocial Disability Support

To create recovery-oriented psychosocial disability support requires significant changes in ways of working not only for the workforce but also cultural change in services. Achieving this lasting change to deliver optimal recovery-oriented psychosocial disability support in the NDIS requires long-term strategy and planning. In the mental health and disability sectors there has been extensive change and reform in recent years and planned for the near future.

In 2019 the Department of Social Services engaged in consultation and planning for NDIS workforce development. As stated in the *Growing the NDIS Market and Workforce* report "given the scale and pace of reforms to the disability support sector, the Government recognises the need to support business and workforce development while the market transitions and matures" (Department of Social Services, 2019, p. 1). The four priorities of the plan are 1, to optimise the NDIS market and support investment, 2, building the capability of NDIS providers and 3, NDIS workforce capability, and 4, grow the NDIS workforce. Additionally, within these priorities are strategies to address current challenges such as thin markets in rural areas (Department of Social Services, 2019).

In the same year, National Disability Services (NDS) commissioned a scoping review to explore the development of a Disability Skills Portfolio for the disability workforce to enable centralised tracking of micro-credentialling and other credentialling requirements for disability roles (Snell et al., 2019). Micro-credentialling can enable the workforce to engage in areas of recovery-oriented practice in small achievable steps, that can be centrally managed (by a peak body).

The current National Disability Strategy 2010-2020 details six areas of policy action that could be the focus for micro-credentialling:

1. Inclusive and accessible communities.
2. Rights protection, justice and legislation.
3. Economic security.
4. Personal and community support.
5. Learning and skills.
6. Health and wellbeing

(Commonwealth of Australia, 2011).

Due to be released mid-year, in 2021, the new National Disability Strategy will outline the vision, and reinstate the previous areas of policy action. The proposed vision for the new strategy is "an inclusive Australian society that enables people with disability to fulfil their potential as equal members of the community" (Department of Social Services, 2020, p. 6). Informed by the UN Convention on the Rights of Persons with a Disability (UNCRPD) (2006), the guiding principles to inform the next strategy are: involve and engage, design universally, engage the broader community, address barriers faced by priority populations, and support carers and supporters (Department of Social Services, 2020).

Further information:

National Disability Strategy 2010-2020
National Disability Strategy Position Paper

Recommendations

In the short term, recommended changes to foster recovery-oriented psychosocial disability support involve:

- Developing recovery-oriented psychosocial support guidelines (see workforce and organisational capabilities).
- Supporting the use of NDIS recovery-oriented psychosocial support training packages or recommended training (see recovery-oriented practice training).
- Promoting coproduced peer led services, as well as fostering lived experience leadership, training, and support, drawing on lived experience perspectives (see Peer Work).
- Supporting leadership and cultural change in recovery-oriented psychosocial support (see organisational capabilities and building workforce capacity).

In the medium term, changes may include:

- Creation of psychosocial disability workforce standards.
- Credentialling and micro-credentialling training programs.
- Provision of support and supervision for psychosocial support workforce, including lived experience supervision.
- Further developing lived experience leadership and quality support, including career mobility for the peer workforce.
- Establishment of communities of practice for lived experience Recovery Coaches.

In the long term, ideal recovery-oriented service provision will include:

- Coproduced recovery-oriented services or organisations.
- Provider credentialling and organisational accreditation processes.
- Sector wide recovery-practice training.
- Endorsement of services as recovery-oriented by relevant peak bodies, a ‘Recovery-Oriented Tick-of-Approval’.

Innovative Examples of Recovery-Oriented Practice and Training

To illustrate good practice in recovery-oriented psychosocial disability support, there are several notable examples of programs and training within the psychosocial disability context, albeit that not all are currently available through the NDIS. As noted in the *Current Landscape Stage One report*, there is a paucity of research specific to the NDIS context but a mix of academic and grey literature provided some of the examples below. Other featured programs and training arise from consultation with the Project Reference Group (PRG), other project stakeholders, and known examples from the research team (see methods section).

Psychosocial Disability Support Program Innovations

Within the NDIS and broader psychosocial disability sector, in Australia and internationally, there are multiple examples of programs that utilise an innovative recovery-oriented approach to service provision. Leading from the *Current Landscape* report, these examples utilise different elements of recovery-oriented practice. For example:

- The National Community Connectors Program seeks to address barriers to accessing the NDIS for community groups that experience inequities in service provision.
- The Uniting SA NDIS Peer Support Program utilises a lived experience workforce to promote inclusion and to support the recovery journey of people with a psychosocial disability who are NDIS participants.
- Recovery colleges utilise a coproduced model supporting recovery, empowering and educating people with lived experience, families, and carers, whilst developing the recovery-orientation of mental health workers.
- The Project from Wick, Scotland utilises a community development approach which seeks to empower the local community, promote community participation, and social inclusion.

NDIS Psychosocial Community Connectors Program

The NDIS Psychosocial Community Connectors Program (Community Connectors) was created in partnership with Mental Health Australia (MHA) to improve access for people with psychosocial disability to the NDIS in areas where uptake had low numbers (Mental Health Australia, n.d.). The broader National Community Connectors Program was established by the NDIA to assist several community groups access the NDIS Aboriginal and Torres Strait Islander communities, Culturally and Linguistically Diverse communities, People experiencing psychosocial disabilities, and ageing parents or carers of people with disability (NDIS, 2020d). Notably, this program has not received continuing funding.

The program objectives of the Community Connectors are to:

1. Support people with psychosocial disability living in the pilot site(s) to engage with the NDIS.
2. Increase community members understanding and awareness of the NDIS.
3. Soundly monitor and evaluate the program.
4. Engage with community members and program participants in a respectful and satisfactory way

   (Mental Health Australia, 2020).

Further information:

Program Outline – Mental Health Australia
National Community Connectors Program – NDIS

UnitingSA – NDIS Peer Support Program

In South Australia, the Uniting SA NDIS Peer Support Program (Mackay et al., 2019) is a pilot project aimed at continuing psychosocial supports under the NDIS, that had previously been provided under a block funding model.

The people supported under the program with "severe mental illness, with complex comorbidities including acquired brain injuries and other physical and psychosocial disabilities" (Mackay et al., 2019, p. 4). As stated in the program description:

> UnitingSA developed the NDIS Peer Support Program to try and provide the person-driven, recovery-oriented supports these people had been receiving, and wanted to continue receiving. The new pilot service provides assertive, trauma-informed, recovery-oriented outreach support by a lived experience team (Mackay et al., 2019, p. 4).

As Mackay et al. (2019, p. 4) suggests, NDIS packages for people with a psychosocial disability should have allowances "for the episodic nature of mental illness in relation to hours, plan flexibility and crisis support when needed, for the NDIS to deliver a truly person-driven model."

Chiefly amongst the program's challenges was financial viability under the NDIS model (Mackay et al., 2019). Notably, UnitingSA (Mackay et al., 2019) reported that transport mileage and insufficient on-costs for supervision were the key financial barriers.

Further information:

UnitingSA NDIS Peer Support Program Evaluation – Final Report

Recovery Camp

The Recovery Camp was developed at the University of Wollongong to engage people with mental health conditions in therapeutic recreation, engage in research and to provide experiential learning of recovery for both staff and people with lived experience (McPherson, 2016). The Recovery Camp is community based, recovery-oriented and values lived experience (Taylor et al., 2017). Since the first camp in 2013 multiple Recovery Camps have been opened, providing services to NDIS participants, carers, people with mental health conditions, student placements and health professionals (Recovery Camp, 2021a).

Recovery Camps currently offer NDIS participants capacity building supports such as:

- Increased social and community participation.
- Improved health and well-being.
- Improved daily living.
- Daily tasks/shared living.
- Innovative community participation.
- Development-life skills.
- Participate in community.
- Therapeutic supports.
- Group/centre activities.

(Recovery Camp, 2021b).

Participants attending the Recovery Camps undertake therapeutic recreation activities designed to facilitate individual engagement, develop positive therapeutic relationships and teamwork (Taylor et al., 2017). Research with the Recovery Camps found that participants who attended the camps reported an increase in self-determination which was measured with the Self-Determination Scale (Taylor et al., 2017). Participants reported increase in both domains of the Self-Determination Scale, awareness of self and perceived choice in ones actions (Taylor et al., 2017). Notably, there was little difference between the control group and the Recovery Camp group in the three month post camp evaluation, suggesting that self-determination may decrease once the participant returns to their usual activity (Taylor et al., 2017). Research with nursing students who attended the Recovery Camp on placement found that it improved their understanding of stigma, professional knowledge, applied skills, and insight into recovery and the participant's recovery journey (Perlman et al., 2017).

Further information:

Recovery Camp Website

Other Innovations

The following briefly provides examples of national and international innovations that have the potential to inform good practice in recovery-oriented psychosocial disability support that were recommended in our discussions with experts and via the literature review. These also include examples of innovation integrating recovery-oriented practice with clinical service delivery but excludes residential services such as sub-acute and community care units although this has been well documented elsewhere (Fletcher et al., 2019; Parker et al., 2019).

Partners in Recovery, Personal Helpers and Mentors, and Day to Day Living

Although now ceased, there is potential to learn from evaluation and research that has investigated recovery-oriented Commonwealth mental health programs and also the experience of their transition in to the NDIS. Programs included Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs), and Day to Day Living (D2DL) (Hancock et al., 2019).

Further information:

Evaluation Report – Commonwealth Mental Health Programs Monitoring Project Tracking transitions of people from PIR, PHaMs and D2DL into the NDIS

Recovery Colleges

Recovery Colleges deliver peer-led education and training designed to support people with lived experience, families and carers in their recovery journey (Perkins et al., 2012). The key principles of the Recovery College model are education, collaboration, personal strength, inclusivity, and the development of a safe learning environment (Muir-Cochrane et al., 2019).

Recovery Colleges are an international phenomenon which have been shown to be beneficial to recovery in several areas including wellbeing, goals, knowledge, self-management, and social support, whilst reducing stigma and service use (Theriault et al., 2020). Australia now has Recovery Colleges operating in most States and Territories including Discovery Colleges designed for youth. As Hall et al. (2018) states "Recovery Colleges may enhance the potential for genuine choice in the Scheme through offering an alternative recovery focused environment that is achieving positive outcomes in relation to economic and social inclusion". In Australia, Recovery Colleges are generally block funded by state governments however, some colleges also utilise partial or full NDIS funding.

Further information:

ImROC – 3. Recovery College Resources
WA Recovery College Alliance – Website

Social Prescribing

Social prescribing is an approach for assisting people with complex health and wellbeing needs to access non-clinical health, welfare, and social support services (Rhodes & Bell, 2021). As Rhodes and Bell (2021, p. 2) state, "the aim of social prescribing is to improve health outcomes and reduce the burden on health services by addressing the social determinants of health, as well as empowering people to live more healthy lives" (p.2). Such innovative and responsive services distinct from conventional mental health services are important to enable social and community participation (Baxter and Fancourt (2020).

In Australia, social prescribing has been utilised by the Plus Social Program in Queensland, and the Plus Social pilot program in New South Wales (Aggar et al., 2021; Primary and Community Care Services, n.d.). The Plus Social program assists people with complex mental health conditions with care coordination and linkage to community-based social care services and structured social activities (Aggar et al., 2021). The referred services are designed to address a broad range of needs across multiple biopsychosocial domains including:

- Physical health (medication management, disease-specific groups, diet, exercise).
- Psychological health (support groups, counselling).
- Welfare (food, housing, employment).
- Social support (group activities, befriending services)

  (Aggar et al., 2021, p. 189).

Further information:

Plus Social Program - Website

The PulteneyTown People's Project: Wick, Scotland

The PulteneyTown People's Project (PPP) is a social enterprise and community centre based in Wick, Scotland which provides services to the whole of community including people with psychosocial disability (Pulteneytown Peoples Project, 2021). The PPP works collaboratively and in partnership with government, other organisations and with businesses (Community.Caithness.Org, 2020). As described in their aims:

- We wanted to provide services that people in the area wanted. We put out questionnaires to get ideas, and then, using the wishes of the community, set about sourcing funding for these initiatives.
- We aim to support all ages in identifying and raising their aspirations by offering social, recreational, learning, and work opportunities.
- The Pulteneytown People's Project brings the entire community together, working with everyone from soon-to-be-mums, children, teenagers, right through to older citizens.

  (Community.Caithness.Org, 2020).

Unlike many other community programs the PPP is not block funded by the government but utilises a mix of funding from grants, money raised through business partnerships and fees for services, and a large number of volunteers (MacNab, 2020). Notably, the PPP provides training for people, including

roles such as employability coaching, in-care work (aged and disability services) and employment in areas such as their café and in programs (Pulteneytown Peoples Project, 2021). Care services provided with PPP include community groups, classes, home care packages, acupuncture, SMART recovery amongst many others (Pulteneytown Peoples Project, 2018).

The PPP works with people experiencing/who are:

- Autism spectrum disorders.
- Learning and physical disabilities.
- Substance use.
- Justice system involvement and parolees.
- Mental health consumers.
- Benefit and welfare needs.
- Young families.
- Young people in College or seeking progression.
- Volunteering.

(Pulteneytown Peoples Project, 2018).

Further information:

PulteneyTown People's Project – Facebook Page
PulteneyTown People's Project – Description and Community Website

ParachuteNYC Program

The ParachuteNYC Program is designed to provide an alternative to hospitalisation through a crisis response utilising a combination of the Open Dialogue and Intentional Peer Support models (Wusinich et al., 2020). The program represents an innovative example of successful partnerships with clinical and peer workers that can improve the recovery-orientation of services, and the benefits of early intervention delivered in-home (Wusinich et al., 2020). Notably, the ParachuteNYC Program is now being trialled in the UK (Sykes, 2015).

Further information:

Wusinich et al., 2020, Experiences of Parachute NYC: An integration of Open Dialogue and Intentional Peer Support
ParachuteNYC Project – Newspaper Article

Practice Development and Recovery-Oriented Practice Training

Within the mental health and disability sectors are numerous examples of training and professional development activities that assist workers to improve their knowledge and skills in recovery-oriented psychosocial support. Key desirable features of training programs are those that include lived experience inclusion or are codesigned, are evidence informed and aligned with recovery principles.

Psychosocial Learning Hub, Mental Health Victoria

Mental Health Victoria (2020) developed the Psychosocial Learning Hub as a pilot professional development program arising from the NDIS Workforce Development (Psychosocial Capabilities) Project. The Psychosocial Learning Hub is a micro-learning program designed to assist support workers, support coordinators and supervisors in building foundational psychosocial disability and mental health capabilities (Mental Health Victoria, n.d.-b). The modules within the learning program are:

- Fundamentals of psychosocial disability and mental health challenges.
- Engagement and relationship building.
- Dignity of risk, safety and wellbeing.
- Collaboration.
- Supporting self-determination and achievement of goals.
- Self-reflection and continuous learning.
- Psychosocial disability capabilities for supervisors

  (Mental Health Victoria, n.d.-b).

Further information:

Psychosocial Learning Hub – Website
Psychosocial Learning Hub – FAQs

Structural Competency

An emerging area of training in the mental health and medical fields is in structural competency. Structural competency enables workers to engage with participants within a holistic framework that accounts for understandings from the social model of health (Gajaria et al., 2019). As discussed in the *Current Landscape*, an understanding of the impacts of structural factors on a person's life is an essential component of recovery-oriented practice. Most notably, areas such as the impacts of homelessness, poverty, racism, gender, sexuality and other factors that can create inequitable health outcomes and impact wellbeing (Neff et al., 2020).

Further information:

Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities

Collaborative Recovery Model and Training Program

The Collaborative Recovery Training Program was developed by the University of Wollongong emerging from the Collaborative Recovery Model (CRM) (Oades et al., 2017). As noted in *the Current Landscape*, CRM is an evidence-based training program developed in Australia for mental health workers in recovery-oriented practice.

The four central tenants of CRM are:

- Change enhancement.
- Collaborative needs identification.
- Collaborative goal setting and striving.
- Collaborative task assignment and monitoring

(Oades et al., 2005).

CRM training focuses in two areas: creating a 'shift in attention' and a 'shift in style' through coaching workers to develop their practice to be person-centred, relational and strengths focused; it is perceived as valuable in supporting recovery by mental health consumers (Wolstencroft et al., 2018).

Further information:

Collaborative Recovery Model – Website
Collaborative Recovery Training Program, Intervention and Coaching - Manual

REFOCUS/PULSAR

REFOCUS is a large scale project developed in the UK to assist mental health services to become recovery-oriented (Bird et al., 2018). In Victoria, the Principles Unite Local Services Assisting Recovery (PULSAR) project adapted the REFOCUS manual and training (Meadows et al., 2016; Monash University, 2021). The project engaged in research and co-delivered staff training activities with general practitioners, clinical community mental health services (Monash Health) and mental health community support services (Mind Australia and ERMHA) (Meadows et al., 2019). Findings from this project indicate that staff training in recovery oriented practice can lead to positive change for individuals accessing these services.

REFOCUS/PULSAR has two components: recovery-promoting working relationships, whereby workers develop skills in a coaching approach; and a set of working practices for supporting personally-defined recovery, whereby workers engage in training and support for behavioiur change for:

1. Understanding values and treatment preferences
2. Assessing and amplifying strengths
3. Supporting goal-striving by the service user as a primary focus for staff action

(Bird et al., 2018; Meadows et al., 2016).

Further information:

PULSAR Project – Website
PULSAR Manual for Secondary Care Staff (Specialist and Community Mental Health Services)
REFOCUS Project – Website
REFOCUS Manual 2nd Edition

The Wellness Recovery Action Plan

The Wellness Recovery Action Plan (WRAP) was developed by people with lived experience in 1997, to assist others in self planning their recovery. WRAPs are a peer-led intervention that promotes self-advocacy (Jonikas et al., 2013). Research found that WRAPs were associated with higher levels of self-advocacy which has flow on effects of greater hopefulness, quality of life, and reduced symptoms (Jonikas et al., 2013). WRAP training in Australia empowers participants to "take charge of your own mental health and guides through a process of self exploration" (The Wellness Initiative, 2018).

Further information:

WRAP Training – The Wellness Initiative Website
WRAP – Website

Supported Decision Making Training

As set out in the UNCRPD (2006), "respect for a person's autonomy including the freedom to make one's own choices" underlines the importance of supported decision making, which is embedded in both mental health and disability policy at state and federal levels. Supported decision making is vital to ensure that participants are fully engaged in the decision making process.

As outlined in the *Guidelines for Supported Decision-Making in Mental Health Services* there are four enablers of supported decision making:

1. Legal and rights-based mechanisms, including advance statements, nominated persons, second opinions and advocacy services;
2. Interpersonal strategies, including communication skills;
3. Empowering consumers, including through encouraging choice and self-efficacy; and
4. Management and leadership, including through staff support and development and recognising good practice

   (Brophy et al., 2018, p. 17).

Further information:

Guidelines for Supported Decision Making in Mental Health Services
IMHA Supported Decision Making – CMHL Training
NDS Supported Decision Making – eLearning Module

Trauma Informed Practice

Trauma informed practice training assists workers to understand and respond to trauma, and the challenges experienced by people with a trauma history (Blue Knot Foundation, 2021). The Mental Health Coordinating Council (MHCC) (2019) has developed the Trauma-Informed Care and Practice Organisational toolkit to enable a trauma informed organisational and practice culture.

In addition to trauma informed practice, the Power Threat Meaning Framework (PTMF) offers a recovery-oriented approach to understanding trauma and distress. As stated by the Blue Knot Foundation (n.d.) "the Power, Threat, Meaning Framework fosters respect for the many ways in which distress is experienced, expressed and healed across the globe".

In South Australia, The Just Listening Community (2021) is a new program of the Humane Clinic, which aims to provide a therapeutic environment and community space to support people experiencing distress, crisis, or suicidality as an alternative to other services. A range of training is also provided through the Just Listening Community, including Emotional CPR, use of the Power Threat Meaning Framework (PTMF) and Just Listening training to foster connection through listening and being heard (Just Listening Community, 2021).

Another trauma informed and recovery-oriented practice training is the Hearing Voices Approach by Voices Vic (Uniting, 2021). The Hearing Voices Approach aims to provide knowledge of the experience of hearing voices and recovery, new approaches to working with people who hear voices, and to increase

awareness and understanding of a person's voices (Uniting, 2021). The training is designed for people who hear voices, workers, and friends and family members of a voice hearer (Uniting, 2021).

Further information:

Trauma-Informed Practice Training – Blue Knot Foundation Website
Trauma-informed Care and Practice Organisational Toolkit (TICPOT) – MHCC Website
Power and Threat Meaning Framework Training – Blue Knot Foundation Website
Just Listening Community – Website
Voices Vic – Uniting Website
Voices Vic – Training Schedule

Responding to Distress

There are numerous training programs that assist workers to respond to distress and engage in suicide prevention. The following examples are included where they are used extensively in the psychosocial context, are peer-led or coproduced.

- Emotional CPR is a preferred training program for many peer workers. It is based in a number of support approaches including trauma-informed care, personal recovery, counselling after disasters, peer support, and cultural and social attunement (VMIAC, 2021).
- Mental Health First Aid training is an evidence-based program designed to provide the knowledge and skills for all people to respond to distress, it has been available in Australia since 2000 and is utilised in many workplaces (Mental Health First Aid Australia, 2019).
- Alternatives to Suicide is a peer-led and trauma informed suicide prevention approach developed in the US (Helping Minds, 2018).
- Applied Suicide Intervention Skills Training (ASIST) is a evidence-based suicide intervention module that was developed to assist people to recognise and respond to suicide risk (Living Works, 2014).

Sane has developed a guide to help mental health professionals support people who are experiencing suicidal thoughts and behaviours. The guide examines suicide prevention through the lens of recovery. It encourages mental health professionals to work on:

1. Building a positive working relationship with the consumer.
2. Considering risk assessment in a way that fully engages with the consumer.
3. Working collaboratively with family and friends.
4. Supporting the consumer's independence and decision making.
5. Supporting the consumer in times of transition between services and discharge.
6. Promoting recovery and building resilience.
7. Communicating respectfully when talking about suicide and mental illness.
8. Providing support to families and friends after suicide.
9. Staying healthy themselves by engaging in self-care and distress tolerance.
10. Continued professional development and training in suicide prevention.

(Sane Australia, 2014, p. 3).

Further information:

Emotional CPR Training – VMIAC Website
Mental Health First Aid Training – Website
Alternatives to Suicide Training – Website
Applied Suicide Intervention Skills Training – Website
Suicide Prevention and Recovery Guide

Cultural Safety

There is guidance available to ensure a recovery orientation in psychosocial disability support includes enabling cultural safety for all participants of NDIS services and their families. Notably, cultural safety, diversity and inclusion training should include awareness of the support and cultural needs of people who identify as LGBTIQ+, Aboriginal and Torres Strait Islander communities, and culturally and linguistically diverse communities.

As aforementioned, culturally safe services are a significant barrier for Aboriginal and Torres Strait Islander communities to access the NDIS. The peak Aboriginal Community Controlled Organisation from each state can either deliver or assist to locate cultural safety training appropriate to the local area and for the local Aboriginal and Torres Strait Islander Communities. For example, the Victorian Aboriginal Community Controlled Health Organisation, the peak body for Aboriginal Community Controlled Organisations in Victoria, offers cultural safety training tailored to the organisation's needs.

- The Equality Project provides multiple training programs for organisations, including awareness and inclusive practices (The Equality Project, n.d.).
- The Centre for Cultural Competence (n.d.) offers Cultural Competence Training for organisations, including a consultation service. Notably, their training packages are designed as a foundational base or as a pre-cursor to more in-depth or localised training (Centre for Cultural Competence, n.d.).
- The Aboriginal Cultural Safety training developed by the Victorian Aboriginal Community Controlled Health Organisation (2021) is designed per the Cultural Safety Training guidelines from the National Aboriginal Community Controlled Health Organisation.
- Settlement Services International (n.d.) has developed the CultureReady program for NDIS providers to work more effectively with people from Culturally and Linguistically Diverse communities.

Some organisations also offer resources to assist in organisational change and development to promote inclusion. For example, LGBTIQ+ Health Australia (2020) has released the EmployableQ Disability Employment Inclusion Toolkit.

Further information:

The Equality Project – Website
LGBTIQ+ Health Australia – EmployableQ Disability Employment Inclusion Toolkit
Cultural Competence Training – Webpage
Aboriginal Cultural Safety Training – VACCHO Webpage
Settlement Services International - CultureReady for NDIS Workforce

Coaching

Coaching skills and approaches are included in several recovery-oriented practice training programs such as Intentional Peer Support (n.d.), PULSAR (Meadows et al., 2016) and CRM (Deane et al., 2010; Oades et al., 2017). Within the NDIS context, the independent advisory council recommended the inclusion of a life coaching support item (Kaplan & McGrath, 2018), and the creation of the Psychosocial

Recovery Coach role (National Disability Insurance Scheme, 2020). Coaching in psychosocial support assists to promote self-efficacy and self-determination.

Further information:

PULSAR Manual for Secondary Care Staff (Specialist and Community Mental Health Services)
NDIS Psychosocial Recovery Coach - Website

Community Participation

The Temple University Collaborative on Community Inclusion (2016) offers training, research and organisational development resources to support the full and meaningful community participation of individuals with mental illnesses. Additionally, Jump-Starting Community Living and Participation (Baron, 2018) is an organisational development toolkit to improve the community participation and integration of services. Jump-Starting Community Living and Participation (Baron, 2018) is an organisational development toolkit to improve the community participation and integration of services. The Action Over Inertia program incorporates a recovery-oriented approach to supporting engagement with the community for people with mental health conditions and psychosocial disability (Rees et al., 2021). Initially developed in Canada, it has also been used by peer support workers and occupational therapists, in the US and Australia (Rees et al., 2021).

Further information:

Temple University Collaborative on Community Inclusion – Training Website
Jump-Start Community Living and Participation – Toolkit
Action Over Inertia - Brochure

Enabling Risk Training

The importance of enabling dignity of risk in recovery-oriented practice has been outlined in the Stage One *Current Landscape* report. Positive risk taking is outlined in training programs such as PULSAR (Meadows et al., 2016), CRM (Oades et al., 2017), and the Psychosocial Learning Hub (Mental Health Victoria, n.d.-b). Representing the overlapping values between recovery and disability support, learnings from the disability sector provide best practice training and development resources. Created at the La Trobe University Living with Disability Research Centre, the Enabling Risk: Putting Positives First training has been developed specifically for disability support workers (Bigby et al., 2018). The training resource is designed for people with cognitive disabilities, however, has applicability to psychosocial disability. The training assists support workers to support people engage in activities and make choices that can involve risk whilst minimising potential harms (Bigby et al., 2018).

Further information:

Enabling Risk: Putting Positives First – Training Modules

The Bouverie Centre – Working with Families and Carers

The Bouverie Centre is an integrated service that combines clinical family therapy, academic teaching, research, workforce development and community education (State of Victoria, 2021b). As identified by the Royal Commission into Victoria's Mental Health System (State of Victoria, 2021b, p. 102) "many service providers do not feel adequately trained to work in a way that involves a consumer's social context". The Bouverie Centre provides extensive training for service providers and practitioners to improve in carer and family engagement and involvement (The Bouverie Centre, 2021).

Further information:

Bouverie Centre - Training

Peer work – A contemporary example of workforce development

Peer workers are individuals who utilise their own lived experience of mental health challenges and personal recovery for the purpose of supporting other people (Stratford et al., 2019). At times, peer workers may also be referred to as Lived Experience workers. Lived experience workforce roles include consumer leadership, peer support work, education and training, advocacy, consulting and advisory roles (Meagher et al., 2018). Victoria first introduced peer workers in 1996 to support quality improvement in area mental health services. Since then, the peer workforce has grown throughout the mental health system. However, this emerging discipline has faced enormous challenges during this implementation process, including lack of organisational and workforce support; insufficient supervision and managerial support; role drift and co-opting; as well as stigmatisation and workplace isolation (Byrne et al., 2015; L Byrne et al., 2018; Byrne et al., 2019). The peer workforce will likely face many challenges to come as they seek to overcome pre-conceptions, establish themselves as a well-understood professional discipline, and strive to establish equitable workforce conditions on par with other mental health professionals. In this context, there are many parallels between peer workers and the emerging NDIS workforce.

Training and Education

As mentioned in *The Current Landscape* Stage One of this project, the training for peer workers has long been established, but also can be difficult to access. In Victoria there are two principal training offerings for peer workers i) Intentional Peer Support (IPS) (Intentional Peer Support, n.d.); and the Certificate IV in Mental Health Peer Work (Myskills, 2020).
State-wide trainers such as The Centre for Mental Health Learning (CMHL) provide some peer-focused training. The 2021 CMHL training calendar includes peer-led models such as 'Hearing voices approach training' (cost not stated) and 'Foundations of peer work' ($450 for 5 sessions). Limited amounts of peer training may also be available via organisations' training calendars or private/independent training (see: Responding to Emotional Distress).
The RCVMHS also announced a new Lived Experience led organisation which will deliver accredited training and resources to support organisations which are consumer-led (State of Victoria, 2021c).

Further information:

Intentional Peer Support – Website
Certificate IV in Mental Health Peer Work – Course Outline
The Centre for Mental Health Learning – Website

Certificate IV in Mental Health Peer Work

The Certificate IV in Mental Health Peer Work, as well as a 5-day abridged 'Foundations of peer work' course is provided by Mental Health Victoria (Mental Health Victoria, n.d.-a). Released in 2015, the certificate has been difficult to access until recently (National Mental Health Commission, 2015). In its first year it was only available to people who were already employed as peer workers. It has remained available – through a limited number of trainers, and cost upwards of $5000. This has made it inaccessible to many people with lived experience. In 2020, the Certificate IV in Mental Health Peer Work became more widely available due to its inclusion in the 'Free TAFE' program and is now available through a range of trainers (State Government of Victoria, 2021a).

There is significant crossover in the units taught in the Certificate IV in Mental Health Peer Work and other 'Free TAFE' courses such as Certificate IV in Mental Health and Certificate IV in Community Services (Myskills, 2020). The Certificate IV in Mental Health Peer Work includes the following units:

Certificate IV in Mental Health Peer Work (CHC43515)	
CHCPWK001	Apply peer work practices in the mental health sector
CHCPWK004/005	Work effectively in consumer/carer mental health peer work
CHCLEG001	Work legally and ethically
CHCPRP003	Develop and maintain networks and collaborative partnerships
CHCPWK003	Apply lived experience in mental health peer work
CHCMHS003	Provide recovery-oriented MH services
CHCGRP002	Plan and conduct group activities
CHCMHS008	Promote and facilitate self-advocacy
CHCADV002	Provide advocacy and representation services
CHCMHS007	Work effectively in trauma informed care
CHCMHS010	Implement recovery-oriented approaches to complexity
CHCMHS011	Assess and promote social, emotional, and physical wellbeing
CHCPWK002	Contribute to the continuous improvement of mental health services for consumers and carers
HLTWHS001	Participate in WHS
CHCDIV001	Work with diverse people

FIGURE 9: CERTIFICATE IV IN MENTAL HEALTH PEER WORK

Intentional Peer Support

"It is not about developing more effective services, but rather about creating dialogues that have influence on all of our understandings, conversations, and relationships."
– Shery Mead, Founder of IPS (Intentional Peer Support, n.d.).

Intentional Peer Support (IPS) is widely recognised as the seminal peer support training program, in Australia and internationally. IPS has been taught for over 20 years and is available through well-known peer run organisations such as the Self-Help Addiction Resource Centre (SHARC) (n.d.) and other providers.

IPS has four principal trainings:

- Core training (peer support worker)
- Advanced training (peer support worker)
- Train the trainer (trainers)
- Manager training (managers seeking to support IPS practitioners/peer workers)

(Intentional Peer Support, n.d.)

Intentional Peer Support

Competency 1: Connection: Nurtures and cultivates connection with others.
Competency 2: Shifting the focus from Helping to Learning Together.
Competency 3: Worldview: Awareness of Own and Other's Worldview.
Competency 4: Shifting the focus from the Individual to the Relationship.
Competency 5: Mutuality.
Competency 6: Shifting the focus from fear to hope and possibility.
Competency 7: Moving Towards versus Moving Away From.
Competency 8: Self-Reflection.
Competency 9: Able to Give and Receive Feedback.
Competency 10: Co-Reflection.

FIGURE 10: INTENTIONAL PEER SUPPORT COMPETENCIES (Intentional Peer Support, n.d.)

Peer work as a discipline and professional recognition

Often remembered for its pivotal grass roots history, the peer workforce has often fought to be recognised and treated as a skilled professional workforce equal to other frontline mental health disciplines (e.g., allied health). This lack of recognition has contributed to unsupportive workforce conditions such as insufficient peer specific supervision, minimal training opportunities, few opportunities for career advancement, inequitable pay and conditions (Bennetts et al., 2013; Byrne et al., 2015; L. Byrne et al., 2018; Byrne et al., 2019; Productivity Commission, 2020).

The development of the Cert IV in Mental Health Peer Work was seen by some members of the Victorian peer workforce as a step toward legitimising and enriching peer work as a professional practice. It was also seen by some as a way to give employers a better idea about what competencies the graduates had so that they could better match this to the requirements of the roles they were seeking to fill. The Productivity Commission Report recognised the important and unique contribution of lived experience as well as the role of training/PD in developing peer workforce competencies (Productivity Commission, 2020). It also recommends formation of a professional representative body for lived experience workers.

How could the peer workers journey inform NDIS practitioners?

Peer workers and NDIS workers face some common struggles as emerging workforces. Both are emerging workforces whose roles and fit within the boarder system are still forming and still unfamiliar to many. As a result, these roles are often misunderstood, poorly defined, and insufficiently supported. Consumers, carers, and other members of the health system may not understand these roles, how to refer to them or know what they do. Both peer workers and NDIS workers are subject to inequitable remuneration, insufficient organisational/management support (including peer supervision) and fractional appointments which lead to experiences of disadvantage and limited power within services.

Should NDIS workers be trained using peer worker competencies and principles?

The principles and competencies described in peer training may hold relevance for many workers who would like to develop skills in recovery-oriented practice. For example, the competencies outlined in the Cert IV in Mental Health Peer Work and IPS are grounded in recovery-oriented practice and often relevant and applicable to workforces beyond the peer workforce. At this time, both individuals with and without lived experience may undertake the Cert IV in Mental Health Peer Work to learn skills and perspectives to enrich their practice. Nevertheless, the selection criteria for peer worker roles typically require lived experience in addition to training. Other training programs such as IPS may require that an individual has lived experience, and therefore may be less applicable to NDIS workers without lived experience of mental health issues.

Recovery Oriented Psychosocial Disability Support Workforce Capabilities

This section outlines the key workforce capabilities required to deliver recovery-oriented psychosocial disability support. Capabilities are typically defined as encompassing skills, knowledge, values, attitudes, and behaviours. Capabilities for recovery-oriented practice and service delivery encompass all these characteristics in order to support people experiencing mental health conditions to live a life that is self-defined, self-determined, meaningful, and satisfying (Department of Health and Human Services, 2020). Recovery-oriented capabilities can be used as a framework in which to assist the workforce to incorporate and shift practices to be recovery focused. Capabilities are typically organised and categorised under a number of domains. These domains combine several similar capabilities. The following capabilities are categorised under specific domains but there is significant overlap between the domains, and they should not be viewed as discrete.

Workforce Capability Domains

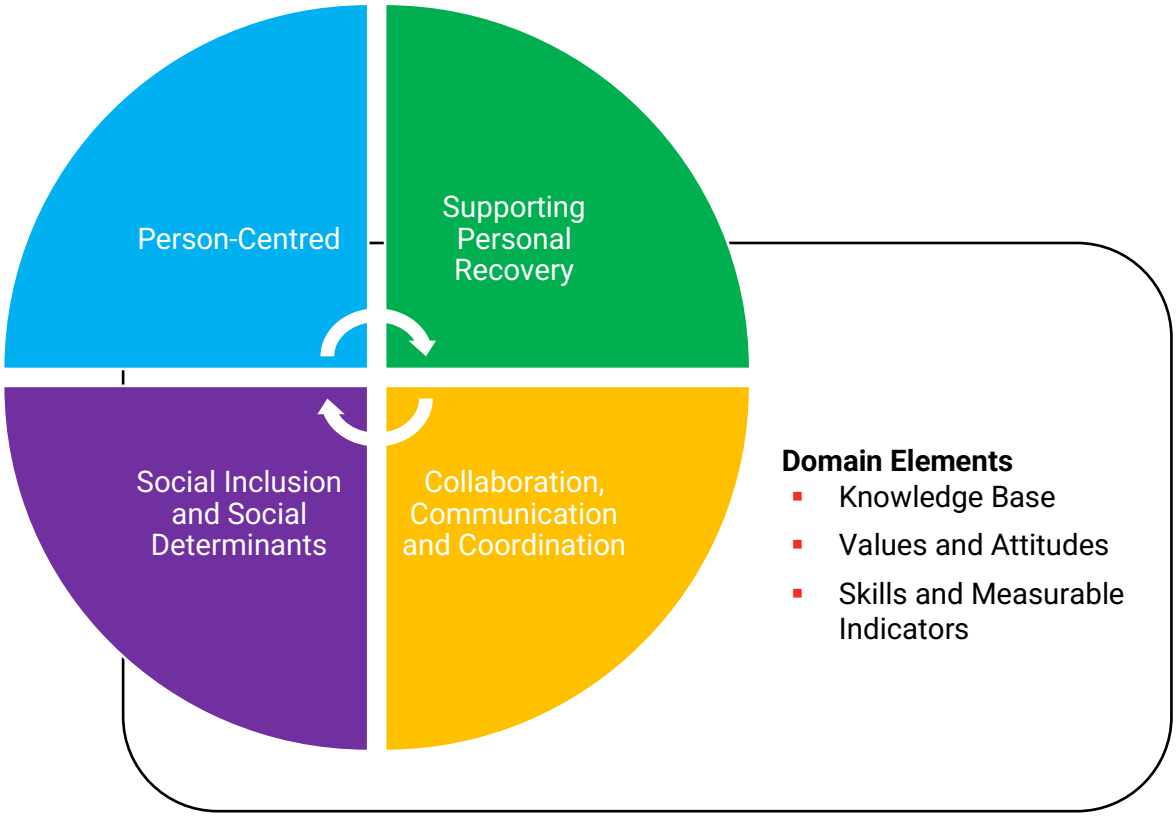

FIGURE 11: WORKFORCE CAPABILITY DOMAINS AND ELEMENTS

Person-Centred

Person-centred, person-led, and person-first

A key element essential to recovery-oriented practice is the emphasis and appreciation of the uniqueness and dignity of the individual experiencing mental health conditions. Person-centred care was defined by de Silva (2014) as a philosophy that sees the individual as being an equal partner in all aspects of service delivery, being at the heart of all decisions. It is the reorientation of all services to be "user-focused, to promote control, independence and autonomy for the patient (sic) and the carers and family, to provide choice and be based on a collaborative team philosophy" (de Silva, 2014, p. 6). It is important to note ongoing tension exists between person-centred and person-led approaches. Use of 'person-centred' terminology has been criticised for implying that the individual has only been considered and thought about, but the decisions have been made by others, such as those working in the mental health system. It is argued that person-led approaches promote self-determination where the individual has led and ultimately made their own decisions (Mission Australia, 2016). This suggests that a person-led approach supports those experiencing mental health conditions to be independent and exercise power over their own support. Despite this tension, this report includes those key capabilities aligned with knowledge and skills associated with person-centred and person-led practices. While consumer or person-led approaches are less well developed than person-centred approaches, moving toward more strongly embracing and demonstrating consumer-led approaches and capabilities within services and workforces is consistent with the emphasis on choice and control in the NDIS. Similarly, it is important to understand the difference between supported decision making and shared decision making (Brophy et al., 2018):

- Supported decision making is a means of enabling consumers to understand choices in relation to their treatment. Consumers receive support in their efforts to make decisions for themselves.

Supported decision making is NOT:

- Shared decision making, which is where the consumer participates in the decision making process but the final decision is not made by the consumer.
- Substitute decision making, which is where a third person makes the decision for the consumer.

Supported decision making in any health or mental health setting, when embedded throughout the organisation, is about much more than having family, professional or community advocates present at key treatment decision making meetings or tribunals. It is a collaborative approach to support an individual in their decision making. Many consumers already use supportive decision-making processes to enhance decision making across other life domains, for example, when having informal discussions with someone who has been through similar experiences or has needed to make a similar decision (RANZCP, 2018).

Key components of the person-centred approach include applying a strengths-based lens and approach, upholding compassion, dignity, and respect for the individual, an approach which seeks to contribute to supporting the journey and pursuit of the individual's aspirations taking into consideration their circumstances. These may be demonstrated via shared decision making, supported decision making, supporting self-management, and proactive communication. Embedding person-centred practice into care or support pathways, systems, workforce attitudes and behaviours, in order to promote choice, shared decision making and supported decision making in healthcare or mental health services is a major challenge. With regard to broad recovery competencies frameworks, the National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers (Australian Government Department of Health, 2013a) outlines recovery-oriented mental health practice and service delivery. One of the five key domains in this framework is 'Person 1st and holistic' describes "putting people who experience mental health issues first and at the centre of practice and service delivery; viewing a person's life situation holistically" (Australian Government Department of Health, 2013a, p. 4). These practices emphasise the importance of self-determination and choice for each participant with a lived experience of mental health conditions, their families and friends, and other supporters. The person-centred skills, knowledge, attitudes, and values needed by the workforce focused on in this report – and

new roles that will continue to be developed in response to consumer-directed care – reflect the paradigm shift being seen in the way services are provided and the understandings of the needs of participants in the NDIS (SkillsIQ, 2017).

Knowledge base

For this domain it is important for workers to have a basic understanding of key concepts and terms as well as a developing understanding of how these are fundamental to the participants they engage with in terms of recovery. These terms and concepts include:

- Having an understanding of and up-to-date knowledge of psychosocial disability, complex support needs, disability more broadly, and the rights of people with disability (Department of Health and Human Services, 2020).
- Having an understanding of both shared decision making and supported decision making.
- Appreciating the importance of human rights, choice and control and understand the legally recognised roles of decision-supporters such as nominated persons.
- Having a basic willingness to learn how participants, their families, and other supporters, as well as different communities and cultures, have various understandings of mental health, disability, and recovery.
    - Having knowledge of specific frameworks, guidelines, and information regarding working with participants from Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse (CALD) backgrounds, and from the LGBTIQ+ community (for example, see National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023) (Department of the Prime Minister and Cabinet, 2017).
- Having an understanding of intersectionality, as also argued for in the Allied Health Capability Framework (Department of Health and Human Services, 2020). Intersectionality is a lens which aids to showcase how systems and structures can interact to impact the recovery and general wellbeing of individuals and groups. It means a participant may have multiple social identities grounded, for instance, in sexualities, cultures, disabilities and so on. This lens can assist a worker and participant to see and understand how privilege, power, and oppression shape a person's sense of power, resilience, and wellbeing.
- Having an understanding of various interrelated domains of wellbeing and recovery important to participants, including clinical, functional, physical and social needs (Davidson et al., 2012). Therefore, support needs may span across these different areas.
    - Understanding the interplay between physical health, mental health, disability and coexisting conditions and the importance of collaboration to address needs simultaneously.
    - Understanding the specific health needs of participants
    - Knowledge of preventative health activities
- Understanding that participants may have experienced trauma and the key assumptions that form the basis of a trauma-informed approach (Read & Harper, 2020):
    - The impact of trauma/s (such as complex, cumulative, and underlying) is pervasive and can impact the person across the lifespan.
    - Most people who have received treatment for mental illness and substance use have trauma histories.
    - Complex trauma frequently arises from childhood abuse and neglect, but not always.
    - Unresolved complex trauma has intergenerational and societal impacts.
    - Learning to assist a person affected by trauma and how to prevent the retriggering of trauma.
    - Impact of trauma on families and carers, including direct and vicarious trauma.

- Having an understanding of recovery and its key facets including hope, personal responsibility, identity, education, advocacy, and peer support (Mead & Copeland, 2000).
    - Knowledge that the facets relating to hope and peer support highlight how heavily informed recovery is by lived experience perspectives and peer support work.
    - People on their journey of recovery have played a crucial role in advocating for person-centred service delivery, choice and control, self-determination, and a focus on having a meaningful life.
    - Understanding a range of personal recovery approaches including those developed by people with lived experience of mental health conditions.
    - Recovery is a subjective experience and therefore there are many definitions and understandings and these may even change over time for the same participant (Slade et al., 2014).
    - The individual nature of personal recovery (Australian Government Department of Health, 2013a).
- Recognising that complexity may arise from the interplay between individuals and their environments, and the capacity of service systems to respond.

Values and attitudes

- Having respect for and valuing of lived experience.
- Valuing and approaching participants as individuals.
- View the participant and their life situation holistically.
- Respecting participants' choices, values, and wishes.
- Respecting participants' rights to self-determination.
- Respecting and supporting participants' decision making capabilities (Australian Government Department of Health, 2013b).
- Reflecting on one's journey as a support worker and how one's personal bias and experiences may impact on practice.

Skills and Measurable indicators

- Communicating effectively (Australian Government Department of Health, 2013a).
    - Providing information and communicate using language accessible by the participant and where appropriate for their supporters.
    - Facilitating access to information, treatment, support, and resources that contribute to a person's recovery goals and aspirations as well as supporting decision making.
- Learning and discussing with participants about their informal supports and resources, including relationships, fulfilling and enjoyable activities, and education, particularly those that further goals and aspirations (Recovery Devon Resource Library, 2013).
    - Acknowledging participants' family, carers, and informal supports.
    - Working in a collaborative manner with the person's supports, understanding that a participant's needs and goals will be best met when there is strong communication between all parties involved.
    - Coordinating and collaborating with a range of relevant services beyond the mental health system including health services, alcohol and drug services, disability services, employment, education, training services and housing services.
    - Utilising information obtained about supported decision making where appropriate (see the following for guidance: SCOPE for Victoria, Family and Community Services, Ageing, Disability and Home Care for New South Wales, and Western Australia's Individualised Services for Western Australia and Guidelines for SDM in Mental Health Services (Brophy et al., 2018).

    - Identifying the physical health needs and health goals of participants (VicHealth, 2014).
    - Engaging in preventative activities with the participant, where appropriate (VicHealth, 2014).

- Approaching participants in a manner that sees them as individuals - not using the same approach for everyone, as each participant will have different needs and aspirations (Khoury & Rodriguez Del Barrio, 2015).
    - Gathering information to understand behaviours, strengths, challenges, interests, triggers, preferences, situations, and context to best accommodate a person's support needs (Australian Government Department of Health, 2013a).
    - Thinking flexibly and tailors interventions to the person (Australian Government Department of Health, 2013a).
    - Reflecting on and adapting the practice to be sensitive to those experiences (Australian Government Department of Health, 2013a).

- View and work in a manner that takes into consideration the unique context and environment that a participant is embedded within.
    - Be responsive to the cultural and linguistic elements by being open to learning and discussing with the participant and their supports (Australian Government Department of Health, 2013a).

Supporting Personal Recovery

This domain describes the universal capabilities of recovery-oriented practice when supporting personal recovery, and is relevant and appropriate for support roles and services working with participants with a psychosocial disability. One of the main components of the NDIS is the individualised funding packaging (Wilson et al., 2018). Individualised or personalisation models of funding such as the NDIS aim to promote choice and control by providing decentralised welfare that enables individuals and their families to access supports based on their individual needs and goals (Camoni et al., 2020). However, individualised funding packages such as those provided by the NDIS have not at this stage been able to maximise participant's choice-making capacities (Wilson et al., 2018). This is important considering, as previously mentioned, at the time of writing this report there is a transition in the NDIS to further increase flexibility and personalisation of funding packages.

Key to recovery-oriented practice is the need to provide support and services that work to elicit and assist participants to lead the kind of life they so wish, taking into consideration personal preferences and interests (Davidson et al., 2012). This domain outlines knowledge, values, skills and behaviours, and measurable indicators associated with promoting autonomy and self-determination; focusing on strengths and personal responsibility; and collaborative relationships and reflective practice (Australian Government Department of Health, 2013a). This is important considering the growing evidence that consumers experiencing mental health conditions, including those deemed severe and enduring conditions, can make decisions that promote recovery; and that if they are offered the opportunity to make choices regarding their treatment, they are more likely to experience recovery (Stanhope et al., 2013). Hence the intersection of the domain of supporting personal recovery with the discussion above regarding respecting person-led approaches, human rights, and supported decision making.

Knowledge Base

For the Supporting Personal Recovery domain it is important for workers to have a basic understanding of key concepts and terms, as well as a developing understanding of how these are fundamental to the participants they engage with in terms of recovery. These terms and concepts include:

- The concepts of autonomy, self-determination, resilience, and choice and control, and how these are fundamental to recovery (Australian Government Department of Health, 2013a; Department of Health and Human Services, 2020).

- Strengths-based approaches to all elements of working with participants including service planning (Australian Government Department of Health, 2013a, p. 61).
- Elements of positive psychology that put emphasis on wellbeing and the person's own goals and strengths (Slade, 2010).
- Collaborative approaches and practice (Oades et al., 2005), including the importance of exploring values and preferences for support with participants (Meadows et al., 2016).
- How individual experiences of disability can influence the support a person may need to make informed choice, and supporting the person where possible to make their own decisions (Department of Health and Human Services, 2020).
- Reflective practice (Australian Government Department of Health, 2013a).

For this domain it is also important to have knowledge of key resources, options and information such as:

- Resource information: list of clear options with cost attached and profiles of staff to choose from; getting information by direct face-to-face contact (Wilson et al., 2018).
- Knowledge of and understanding of the importance of mental health consumer advocacy and carer groups and supporting their involvement in service delivery and decision making.
- Knowledge of and understanding of disability, the rights of people with disability, and rights in service settings (Department of Health and Human Services, 2020)

It is also important to have a growing understanding of:

- The worker's own values, life experiences, and culture that may impact on the relationships and interactions with participants (Australian Government Department of Health, 2013a, p. 31).

Values and Attitudes

For this domain it is also important for workers to bring to their work a set of key values and attitudes when they engage with participants and undertake their tasks. These include but are not limited to:

- Respecting participants' choices, values, and wishes.
- Respecting participants' right to self-determination.
- Respecting and supporting participants' decision-making capabilities.
- Respecting and valuing lived experience.
- Valuing collaborating relationships with participants to work and learn from each other as well as from those important support people in a participant's life.
- Being open to participants' perspectives and opinions as well as being flexible and adaptable to their changing needs and wants.
- Being open to participants' own understandings and definitions of their challenges.

  (Australian Government Department of Health, 2013a)

Skills and Measurable Indicators

- Learning and acknowledging participants' values, beliefs, treatment, and support preferences (Meadows et al., 2016).
    - Communicating and conveying this through verbal and non-verbal communication and a belief in participants' capacity to reach their aspirations and to shape a life rich in possibility and meaning.
    - Working in partnership or collaboratively with participants and seeking participants' views and opinions about their situation.
    - Learning and respecting participants' goals and aspirations.

    - In everyday encounters, including assisting participants directly in their home with everyday tasks, making important contributions to participants' lives and recovery through small acts or micro-affirmations in the form of words, gestures, or actions such as engaging in small talk and even sharing a smile (Topor et al., 2018).
    - Using the right body language and simple actions (such as not answering a phone call when communicating with a participant) can convey to the participant they are being heard and listened to (Topor et al., 2018).
    - Having discussions with participants regarding their views and goals can provide opportunities and create space to explore participants' preferences and understandings of recovery (Meadows et al., 2016).
    - Supporting people to identify personal aspirations, goals and intrinsic motivators, including what's important for the person, what they want out of life, what they see as their most pressing challenges and difficulties, and what they want to do and change as a matter of priority (Australian Government Department of Health, 2013a).
    - Taking care to ensure that participants can participate as much as they wish to in any decision about their day-to-day life.
    - Having honest and open discussion of areas of agreement and disagreement as well as difference in values and priorities (Australian Government Department of Health, 2013a).
    - Collaboratively working through differences of opinion to negotiate and resolve conflict, and establish a mutually acceptable compromise or middle ground (Australian Government Department of Health, 2013a).
    - Supporting participants to build self-advocacy skills which involves supporting participants to use their strengths, knowledge to make involved decisions and choices about all areas of their lives including supports and services (Brophy et al., 2018).
    - Documenting the participant values, beliefs, and preferences information on appropriate records (Meadows et al., 2016).

- Learning and acknowledging their own values, beliefs, and preferences as well as biases and viewpoints underpinning service systems and training (Australian Government Department of Health, 2013a).
    - Developing a sense of self-awareness through reflective practice.
    - Being able to seek support, advice, and supervision when necessary.

- Learning, acknowledging, and assessing participants' strengths (Meadows et al., 2016).
    - Having conversations focusing on strengths with participants and/or family, carers, or other important individuals where appropriate.
    - Using verbal and non-verbal communication including positively framed language and tone to convey to participants the workers' belief in participants' abilities and strengths.
    - Actively supporting people to recognise and draw on their strengths to build recovery skills and capacity for the self-management of their mental health conditions (Australian Government Department of Health, 2013a).
    - Exploring strengths to assist with identifying goals and steps for striving toward those goals (Meadows et al., 2016).

- Building trust and reciprocity with participants.
    - Sharing aspects of one's own life experience where appropriate to empathise with a person as well as to amplify their sense of motivation (Australian Government Department of Health, 2013a, p. 63).
    - Engaging with people in ways that heighten a person's sense of self-agency and personal control (Australian Government Department of Health, 2013a).
    - Actively fostering participants' resilience and recognising its impact on recovery outcomes.

- Promoting independence and informed choice (Department of Health and Human Services, 2020).
    - Enabling formal and informal supports in decision making.
    - Engaging with a range of supports in decision making, including legal mechanisms.
    - Acknowledging and exploring power differences in the therapeutic relationship and their possible impacts (Australian Government Department of Health, 2013a). Small everyday things such as a smile, small talk, and discussions beyond those related to mental health conditions can assist to break down the power dynamics that act to reinforce the differences between workers and participants (Topor et al., 2018).
    - Actively informing participants of their rights in service settings, and supporting them in exercising those rights and removing barriers to their exercise of rights (Australian Government Department of Health, 2013a).
    - Supporting people to enhance their skills for informed decision making, including skills for obtaining, evaluating and applying information (Australian Government Department of Health, 2013a).
    - Fostering participants' belief in their capacity for growth and abilities to fulfil responsibilities and complete tasks.
    - Answering questions, sharing, and discussing with participants knowledge of key information, options, and general information.

Social Inclusion and Social Determinants

The role of social determinants and social inclusion in the wellbeing and recovery journey of individuals experiencing mental health conditions is gaining increasing recognition (Allen et al., 2014). Social determinants include housing, transport, education, employment, income security, healthcare and stigma and discrimination. These social and structural conditions shape the context in which people live, as well as the services and systems they access (Allen et al., 2014). The importance of workers understanding participants' efforts to manage their mental health in terms of recovery, and the impact the social determinants of mental health have on their recovery journey has been previously identified (Reid et al., 2020). The social determinants of mental health provide an understanding of the structural impacts on individuals, and of who is more likely in our society to experience inequity. In comparison, social inclusion, a crucial element of recovery, can stem from being a part of social networks, establishing connections, and engaging in meaningful social and occupational activities within the broader community (Tew et al., 2012).

FIGURE 12: DIG DEEPER (ALYSERURIANI.COM, N.D.).

NDIS planning should consider and incorporate specific goals for employment, housing, education, or engagement in social activities that promote community participation (Lloyd et al., 2006; Salzer & Baron, 2016). There is growing evidence of the specific benefit of focusing on these domains as part of recovery-oriented practice with participants with psychosocial disability (Salzer & Baron, 2016). As participants with psychosocial disability can often become disconnected from the wider community, a crucial element of supporting recovery is a focus on reconnecting, re-engaging, and repairing relationships and connections. As Price-Robertson et al. (2017, p. 5) state, "experiences such as hope, identity, meaningfulness, and empowerment emerge at the intersections between people, their relationships and environments; they are best seen as interactional processes rather than states possessed by any one individual". The Royal Commission into Victoria's Mental Health System (RCVMHS) also recommends that Victoria needs a service system that is attuned to promoting inclusion and addressing inequities (State of Victoria, 2021a).

Knowledge Base

- Understanding of the impact of social and structural factors on participant's recovery journey and current life circumstances (Hansen et al., 2018; World Health Organization, 2010).
- Understanding of social and relational recovery and the importance of connections.
- Knowledge of social inclusion and the effects of social exclusion on mental health.
- Understanding of what constitutes social determinants of mental health.
    - Awareness of the effects of stigma and discrimination and other social consequences related to having a psychosocial disability (Wilkinson & Marmot, 2003).
- Knowledge of local communities and cultures, and the relationship between social determinants and their mental health.
    - Knowledge and awareness of the cultural determinants of mental health.
    - Knowledge that "cultural determinants can inform a strengths-based approach to Aboriginal and Torres Strait Islander mental health. They acknowledge that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety" (Department of the Prime Minister and Cabinet, 2017, p. 9).
    - Knowledge and awareness that the social determinants contribute to the high number of adverse childhood experiences and stressful life events experienced by Aboriginal and Torres Strait Islander people (Department of the Prime Minister and Cabinet, 2017).
- Knowledge of social justice issues, human rights, and service systems, in order to challenge social exclusion and disadvantage, and to advocate for social justice (Hansen et al., 2018; World Health Organisation, 2019).
- Up-to-date local knowledge of information and supports (or where to refer participants to access this information) in the following domains:
    - Housing.
    - Employment.
    - Education.
    - Spiritual/religious communities.
    - Physical activity/leisure/recreation.

Values and Attitudes

- Respecting the unique experiences participants may have due to the role of social determinants.
- Willingness to explore a range of domains such as housing and employment etc., in a respectful manner.

- Awareness of focusing on strengths and abilities while also acknowledging potential barriers and limitations.
- Awareness of worker's own background and biases and the implications for working with participants.
- Willingness to learn from participants, their families, and other supporters, as well as different communities and cultures.

Skills and Measurable Indicators

- Discussing social determinants with participants in regard to their recovery goals.
    - Including participants' family, friends, and/or carers where appropriate in these discussions.
    - Identifying existing strengths and connections that can be built upon.
    - Recognising the possible barriers to connecting with people and communities.
    - Advocating for participants' rights and access to services and resources (World Health Organisation, 2019).
    - Acknowledging the impact of structural factors on participants and their families (Hansen et al., 2018; Neff et al., 2020).
- Supporting participants to connect with their communities.
    - Advocating for participants' rights and access to local communities.
    - Celebrating strengths and successes.
    - Considering and discussing whether current supports and service arrangements enable participants' existing relationships to be maintained.
- Supporting participants to gain access to the supports and the most effective services that work to address the social determinants.
    - Collaboratively working with other services and supports.
    - Communicating identified gaps and unmet needs to the organisation to enable data collection and evidence gathering for advocacy activities
- Discussing social and relational elements of participants' lives.
    - Learning who the important people are in a participant's life.
    - Considering with sensitivity that family relationships can be complex, have varying compositions, and being informed by participants' culture, and preferences. Estrangement may be by choice of the participant (e.g., family violence) or the family group may be chosen rather than by birth.
- Understanding and supporting connections and relationships between participants and those important.
    - Supporting participants and families to identify what recovery means for them.
    - Encouraging participants to better understand and communicate about the role of connections and relationships to mental health conditions.
- Using knowledge of housing, employment, education, spiritual/religious; and physical activity/ leisure/ recreation to support participants in developing goals and living a fulfilling life.
    - Learning participants' goals around each of these domains.
    - Encouraging the setting of specific goals around each of these domains.
    - Openly exploring with participants ways in which goals in these areas may be achieved.
    - Connecting and linking participants with services and supports that promote and develop these areas.
- Learning and supporting discovery of meaningful activities.

- Promoting and assisting with effective coping strategies if necessary.
    - Communicating and demonstrating optimism and belief in participants' abilities.
- Encouraging and supporting the building of participants' capacity to engage with others.
    - Identifying and discussing the role of family, friends, or others in assisting in building capacity.
- Supporting and demonstrating interpersonal skills such as listening, asking questions, and appropriate behaviours in interactions.
    - Encouraging and supporting participants in developing skills that assist with social and relational elements of recovery.
- Engaging in reflective practice to identify workers own biases, beliefs, values, and behaviours, and how that can impact participants and their families.
    - Using language with care, ensuring that it is respectful, empowering, and non-stigmatising (Neff et al., 2020).
    - Not assuming, not judging, not blaming, simply listening to the participant and their families (Neff et al., 2020).
    - Focusing on participants strengths rather than "problem talk" (Fogarty et al., 2018).
    - Seeking supervision and advice to assist in reflective practice activities and create strategies or seek suggestions of changes to improve practice.

Collaboration, Communication and Coordination

This domain is concerned with a range of relational capabilities essential for working collaboratively in order for participants to receive person-centred, coordinated, recovery-oriented support and services. Individuals with psychosocial disability may have multiple and complex support needs, so that a range of services and parties, including families and carers, may be involved in providing care and support to promote recovery (Isaacs et al., 2019; Stewart et al., 2018).

The capabilities outlined below have been informed by the growing body of evidence indicating the importance of collaboration and care coordination to achieve positive outcomes for individuals with psychosocial disabilities (Brophy et al., 2014; Isaacs et al., 2019; Isaacs & Firdous, 2019). The capabilities below derive in part from the lessons learned from the now ended national Partners in Recovery (PIR) initiative based on coordinated care approaches (Brophy et al., 2014). Collaborating, coordinating, and communicating with participants and all services and parties can facilitate and support holistic care that is person-centred.

FIGURE 13: HANDSHAKE: COOPERATE AND CONECT (HAIN, 2019).

Collaborating, coordinating, and communicating clearly are all essential in creating space and opportunity for positive risk-taking by participants. Positive-risk taking can support positive learning opportunities as well as assist individuals in areas of choice, control, and self-determination. Working collaboratively with not only participants but all other stakeholders in the pursuit of supporting participants on their recovery journey is crucial to ensuring the best outcomes.

Lastly, this domain of capabilities addresses the importance of recognising the invaluable understandings of recovery and key contribution of lived experience and peer workforce. The benefits of working collaboratively with the peer workforce and opportunities in terms of role modelling and support for participants has also informed the following capabilities.

Knowledge Base

- Knowledge of services and supports, organisations, workforce, and roles.
  - Knowing the local services and supports available to specific participants.
  - Knowing the inclusion criteria of services and supports.
  - Learning what services offer what supports.
- Understanding of the vision, goals, and aspirations for recovery-oriented practice.
  - Knowledge of how recovery is understood in the workforce.
  - Knowing your own role in contributing.
  - Knowing the roles and responsibilities of other team members in supporting recovery.
- Understanding around effective and successful referral pathways.
- Understanding of the effective ways in which to share information to a range of individuals, including participants.
  - Knowing how best to present and convey important information in a manner that enables participants, families, and others to understand.
  - Understanding that sharing information requires informed choice; and enabling participants to have control.
  - Being aware of the risks associated with information sharing, and remaining person-centred in approach.
- Understanding of the diversity of the workforce and the important roles different workers play in supporting participants.
- Knowledge of and understanding of the important contribution of the peer workforce.
- Knowledge and understanding of the important contribution that families, friends, carers, communities, and others have in regard to participants and their recovery.
  - Knowledge of who is important to work with including elders, interpreters, community leaders, cultural advisers etc.
- Understanding the dignity of risk and the importance positive risk-taking opportunities have to the process of recovery (Meadows et al., 2016, p. 25; Mission Australia, 2018).
- Understanding the responsibilities and roles others may have in the participants' life and/or care.

Values and Attitudes

- Being open to continuing to learn, developing knowledge, and skills.
- Being open to working collaboratively.
- Being open to new ideas and creative solutions to challenges.
- Being respectful of differing opinions and solutions.
- Being willing to seek advice, supervision, or the opinions of others.

- Having awareness of the boundaries and limitations of your role and that of others.
- Seeking out learning opportunities.
- Respecting and valuing lived experience and the knowledge people with lived experience bring to the area of mental health.
- Showing willingness and readiness to reflect on practice and adapt as needed.

Skills and Measurable Indicators

- Assisting participants to access the services, supports, and care they need.
  - Providing advice informed by up-to-date knowledge around services available as well as how to access these.
  - Sharing information in a manner that is understandable to the participant and other relevant parties.
  - Discussing collaboratively with all relevant parties around accessing services, supports, and care from other services.
  - Providing information that supports choice and control.
- Working collaboratively with others including service providers, communities, families, carers etc.
  - Seeking out and connecting with people with lived experience and the peer workforce.
  - Seeking out and connecting with elders, interpreters, community leaders, cultural advisers etc.
- Managing conflict or different opinions regarding options and approaches to supporting and assisting participants.
  - Advocating for the needs and goals of participants.
  - Advocating for a recovery focus.
  - Being aware of own personal bias, values, and experiences in shaping opinions.
- Creating opportunities and space for participants to feel they are safe to express their aspirations, and goals which may involve taking positive risks as part of their recovery journey.
  - Links with understanding dignity of risk and the importance of positive risk-taking opportunities to the process of recovery (Mission Australia, 2018).
  - Communicating openly, honestly and transparently.
  - Discussing and learning from previous challenges: what worked, and what continued to be difficult.
  - Discussing openly the potential growth that positive risk-taking may support, as well as the potential for setbacks and challenges.
  - Assessing and monitoring risks that may be required but remaining open and transparent (Meadows et al., 2016).
  - Communicating with not only the participant but a team approach to create positive-risk taking opportunities to occur.

Organisational Capabilities and Building Workforce Capacity

Extending from the Recovery Oriented Psychosocial Disability Workforce Capabilities which outline the capabilities and enablers at a worker level, organisational capabilities and workforce capacity building focuses on the broader systems and processes for delivering recovery-oriented psychosocial disability support. Building workforce capacity focuses on the process for organisational change to a recovery-oriented approach, and on increasing the skills and training of the workforce. It is important to note that within the NDIS context the auspice, role, and size of providers can vary extensively, from sole traders to large mental health organisations.

Organisational Capability Domains

Organisational capabilities have emerged from current frameworks and literature to enable recovery-oriented services. Notably, an enabling environment is an essential element for staff to engage in high quality service provision that promotes recovery and recovery values and principles. Similar to the workforce capabilities, the domain elements of organisational capabilities focus on the knowledge, values and mission, skills and measurable indicators for organisations to enable recovery-oriented psychosocial support. Where possible, overlaps or repetition between workforce capabilities and organisational capabilities have been avoided.

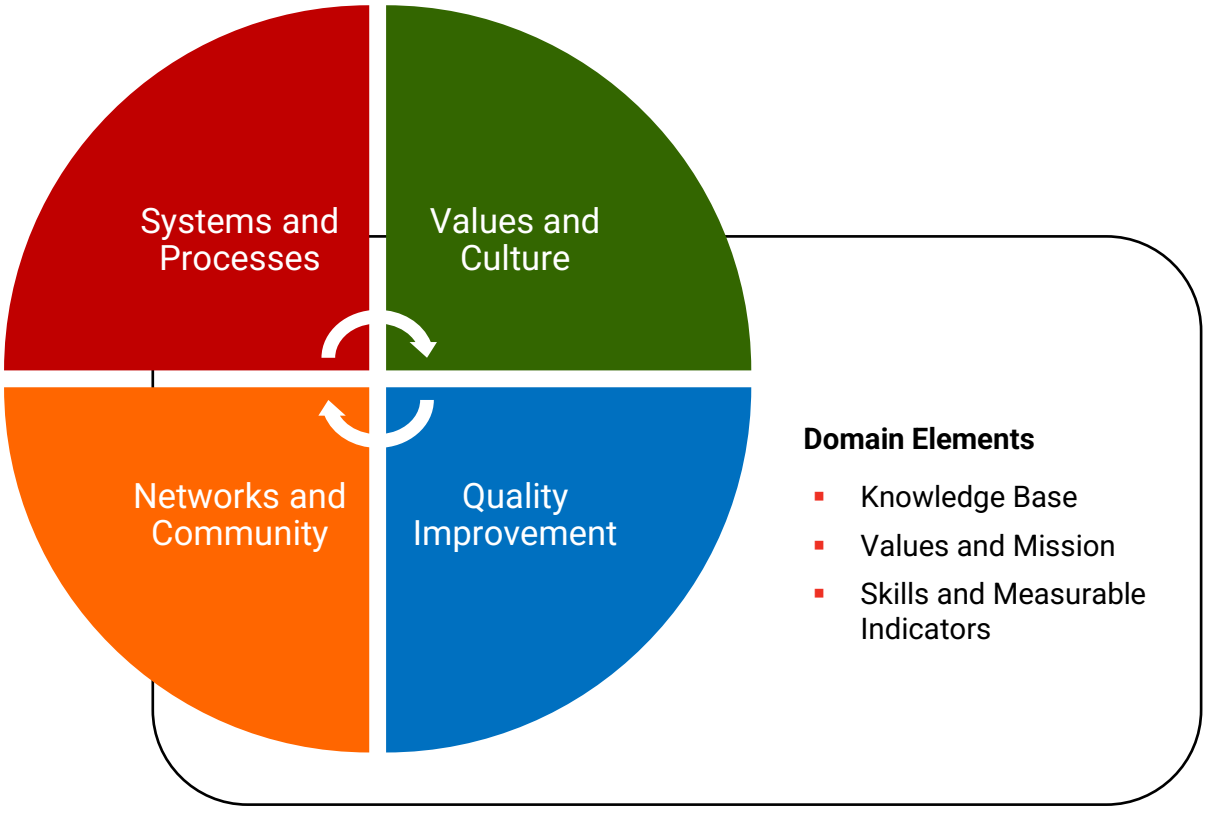

FIGURE 14: ORGANISATIONAL CAPABLITY DOMAINS AND ELEMENTS

Organisational Systems and Processes

The systems and processes in organisations can have a gatekeeping effect on recovery-oriented practice. As Gee et al. (2017) describe, organisational systems and processes can act as enablers or

barriers to recovery-oriented practice. Recovery-oriented practice may impact across almost all systems and processes within organisations including recruitment, service planning, operations, policy, training and development, quality and risk management, depending on the size, scope and services delivered (State of Victoria, 2011). For example, the organisational systems and processes involved for each of the work practices are outlined in the workforce capabilities (see Workforce Capability Domains).

Organisational Values and Culture

As described in the National Framework for Recovery-Oriented Mental Health Services (Australian Government Department of Health, 2013a, p. 65), "a recovery orientation emanates from the vision, mission and culture of a mental health service". In the literature, a successful transition to a recovery-orientation in services is for the organisation to create an environment that promotes its values and principles (Gee et al., 2017). The promotion of recovery in services involves not only setting the values and mission statements, but also in leadership and modelling of recovery values and principles.

Inclusive of creating an environment that promotes recovery-oriented values and principals is acting as agents of social change. As noted in *The Current Landscape*, "addressing adverse social conditions that can detrimentally affect mental health is necessary to support recovery and a key component of recovery-oriented practice" (p. 21). The World Health Organisation (WHO) Quality Rights Guidance module: Advocacy for mental health, disability, and human rights (2019) provides a framework for advocacy activities to promote human rights. As they describe, the tools are designed to provide several key actions to be realised:

> promoting participation and community inclusion for people with lived experience; capacity building in order to end stigma and discrimination and promote rights and recovery; and strengthening peer support and civil society organisations to create mutually supportive relationships and empower people to advocate for a human rights and person-centred approach in mental health and social services (World Health Organisation, 2019, p. xi).

Organisational Networks and Community

Within the disability and mental health sector there has been a continued acknowledgement for the need to improve collaboration and coordination between services (Hughes et al., 2019; State of Victoria, 2021a).
For example, the Royal Commission into Victoria's Mental Health System has recommended the creation of service capability frameworks. One of the key recommendations is to establish "a responsive and integrated mental health and wellbeing system" (State of Victoria, 2021, p. 191). The Mental Health Coordinating Council (2016), produced guidelines for the establishment of Communities of Practice to assist organisations to create networks and partnerships for professional development. Emerging from Victoria's NDIS workforce plan, the Allied Health Capability Framework: complex support needs framework, was established to facilitate allied health staff to work collaboratively, within multiple sectors and to meet the demand for supporting complex needs (Department of Health and Human Services, 2020).

Quality Improvement

Quality improvement and management standards for providers are outlined by the NDIS Quality and Safeguards Commission (2020). Notably these processes can be utilised to ensure recovery-oriented service delivery. Data collection such as service use, incident reports, feedback and evaluations, provide essential information for quality improvement. As described by the Mental Health Coordinating Council (2019), evaluation should involve participant experiences of services, their recovery and efficacy.

Organisational Capabilities

Knowledge Base

- Knowledge of continuing quality improvement activities and keeps up to date with best practice in recovery-oriented principles, resources, and training.
    - Continuing engagement with ongoing professional development and evidence informed tools, resources and training for recovery-oriented practice and organisational change.
- Understanding that the expertise and knowledge required to promote recovery comes from both within and beyond mental health services.
    - Promoting referral networks and sector navigation.
- Engaging in lived experience collaboration and codesign of services.
    - Understanding codesign principles.
- Understanding the role and impact of trauma on participants and their families.
- Understanding the impact of social determinants of health and wellbeing, and their impact on participants' access and usage of services.
- Knowledge of the needs of the local community.
    - Including diverse groups within the community such as people who identify as LGBTIQ+, Aboriginal and Torres Strait Islander Communities and CALD Communities.
    - For example, a sub study in PULSAR found that there were different conceptualisations of personal recovery and a limited level of knowledge or understanding of mental health and mental illness by consumers from two different CALD communities that were investigated, and that concerns about their immigration status impacted on their mental health (Kakuma et al, unpublished).

Values and Mission

- Viewing "the promoting of personal recovery as core business rather than additional business" (Australian Government Department of Health, 2013a, p. 65).
- An organisational commitment to include lived experience perspectives and expertise.
- Inclusion of families and carers
- A commitment to promote autonomy, choice and control, and self-direction.
- Open to change and engaging in quality improvement activities to promote recovery-orientation and lived experience inclusion.
- Promotion of diversity and inclusion
    - Commitment to having culturally safe and inclusive organisations for staff, participants, carers and families, including community and identity groups such as LGBTIQ+, Aboriginal and Torres Strait Islander and/or Culturally and Linguistically Diverse communities.
- Commitment to ongoing quality improvement and to actively seeking feedback from participants and community.

Skills and Measurable Indicators

- Embedding recovery values and language in organisational communication including correspondence, records, and plans.
- Utilising a recovery-oriented mission statement and creation of a strategic plan for embedding recovery into organisational systems and promoting recovery-outcomes.

    - Including “a commitment to proficiency in recovery-oriented practice and service delivery in position statements, service agreements and contracts” (Australian Government Department of Health, 2013a, p. 65).
- Engaging in evaluation and seeking feedback from participants, their families, and carers to improve services and recovery outcomes.
    - Having “effective performance management systems to assess workers’ progress with supporting recovery and providing recovery-oriented services with indicators that are validated as well as relevant and meaningful to consumers and families” (Australian Government Department of Health, 2013a, p. 71).
- Promoting and celebrating recovery successes within the organisation.
    - Utilising a strengths-based focus to promote recovery within the organisation.
    - Celebrating achievements in recovery-oriented practice improvement activities.
    - Attainment of recovery goals and milestones within the organisation.
- Creating a safe working environment, that prioritises the wellbeing and recovery of staff as well as participants.
    - Responding to trauma including vicarious trauma experienced by staff.
    - Providing supervision and support.
    - Clearly defined job roles and responsibilities.
- Promoting recovery-oriented human resource systems and processes.
    - Facilitating the retention and professional development of staff.
    - Promoting quality improvements for the workplace, employing the use of evidence-based recovery evaluations and development activities.
    - “Utilising and supporting engagement with reflective practice” (Mental Health Coordinating Council, 2019, p. 21)
- Fostering recovery-oriented leadership and role modelling within the organisation.
    - Creating opportunities for lived experience leadership, including management positions.
- Supporting the lived experience/peer workforce.
    - Ensuring lived experience/peer worker roles are supported with access to supervision and professional development.
    - Promoting lived experience expertise in the organisation and utilising codesign principles.
    - Inclusion of lived experience in senior roles and board representation.
- Maintaining privacy and confidentiality processes to facilitate the rights and dignity of the participant, carer, and family involvement and appropriate information sharing with other services.
    - Attaining consent (where appropriate) for early engagement with family, carer, and supporters to be involved and consulted with at each level of the planning process and support provision.
    - Having consistent processes and practices in place “that respect and protect the personal privacy and dignity of each participant” (NDIS Quality and Safeguards Commission, 2020, p. 6).
- Promoting collaborative relationships and partnerships with other organisations, local community, and businesses.
    - Promoting community partnerships to facilitate community participation.

    - Fostering collaborative relationships that include organisations beyond mental health and disability services (State of Victoria, 2021a). These include drug and alcohol services (AOD), specialist services, health care providers, justice, housing, family violence, education providers and schools, and others.
    - Utilising networks and technologies to share resources, including shared job roles, peer networks, creating employment opportunities, in-kind resource sharing, use of facilities and equipment.
    - Utilising technology to connect with other organisations to "overcome issues of distance, isolation, lack of services, lack of peer support and limited opportunities for professional support and development" (Australian Government Department of Health, 2013a, p. 40).
- Engaging with practices that promote structural competencies.
    - Ensuring equity of access to services for all participants.
    - Creating provider networks, partnerships, and collaboration activities to meet demand in service gaps, or to gain access to skilled workers and build referral pathways.
- Involving families, carers, and supporters in all levels of planning and support, where possible.
    - Being responsive to and supportive of parenting and/or caring responsibilities.
    - Promoting and supporting relationships and family units.
    - Ensuring "staff are carer aware and trained in carer engagement strategies" (Mind Australia & Helping Minds, 2016).
    - Providing direct support or utilising referral networks to facilitate support for carers.
    - Utilising "technology to facilitate communication with and participation by extended family and kinship networks" (Australian Government Department of Health, 2013a, p. 50).
- Engaging in systems that support and promote cultural safety, diversity, and inclusion for staff and participants.
    - Creating a culture of inclusion.
    - Feeling safe in the workplace.
    - Having accessible recruitment processes.
    - Ensuring appropriate access and adjustments at work (LGBTIQ+ Health Australia, 2020, p. 1).
- Creating a safe and supportive environment for all staff, including those who have lived experience but who have not disclosed or who are not in an identified role.
- Acting as social change agents.
    - Supporting self-advocacy by participants and their families (Gee et al., 2015).
    - Engaging in advocacy activities such as, direct advocacy, lobbying and community action to enact change at a policy and system level (World Health Organisation, 2019).
    - Enabling and encouraging participant and carer participation, consulting with participants to attain an understanding of their needs and issues, identifying service gaps and structural barriers (Gee et al., 2015; World Health Organisation, 2019).

Building Workforce Capacity

Building workforce capacity for recovery-oriented psychosocial disability support involves increasing not only the capabilities of the workforce but also building the capabilities of the organisation in managing change, developing networks, and engaging with evaluation and development activities.

Organisational Change Management

Introducing recovery-oriented practice requires organisational implementation strategies to overcome the barriers to change, as Meadows et al. (2019) described from the PULSAR project. In the UK, ImROC (2009) outlined ten organisational challenges for implementing recovery-oriented practice in mental health services, as listed in Figure 15.

Ten key organisational challenges

1. Changing the nature of day-to-day interactions and the quality of experience.
2. Delivering comprehensive, service user led education and training programmes.
3. Establishing a 'Recovery Education Centre' to drive the programmes forward.
4. Ensuring organisational commitment, creating the 'culture'.
5. Increasing 'personalisation' and choice.
6. Changing the way we approach risk assessment and management.
7. Redefining service user involvement.
8. Transforming the workforce.
9. Supporting staff in their recovery journey.
10. Increasing opportunities for building a life 'beyond illness'.

FIGURE 15: ORGANISATIONAL CHALLENGES FOR RECOVERY-ORIENTED PRACTICE (ImROC, 2009).

In their research, Gee et al. (2017) outline the mechanisms to achieve lasting change that supports embedded recovery-oriented practice in mental health organisations:

- Collaborative action planning between staff and participants.
- Staff feel receptive and supported by colleagues, managers and organisational processes to make changes.
- Planning changes in the organisation account for resistance, change fatigue and factors that block staff engagement.
- Supportive work culture that includes interdisciplinary collaboration, clear communication, supervision, and regular meetings.
- Leadership or champions within the organisation to promote practice changes.
- Management models and promotes changes in work practices, helping staff to feel supported in changes.
- Recovery is embedded in the organisation, including organisational change strategies and identification of potential barriers.

Networks and Communities of Practice

Relationships and coordination are not only an essential element for participant service delivery, but are also crucial for the workforce and for organisations. Provider networks, hubs, Communities of Practice and other workforce networks offer opportunities to share resources, gain information, promote

development, develop practice, and provide support. Notably, these networks facilitated by various peak bodies are already available in many areas.

To support the learning and development of the NDIS psychosocial disability workforce as a part of the Hunter Valley NDIS rollout, the Mental Health Coordinating Council (2016) produced the Guideline for Establishing a Local NDIS Community of Practice to Enhance Learning and Sector Reform. The guideline contains nine key elements for creating a Community of Practice; leadership, size, membership, frequency, format, content, documentation, evaluation and lifespan (Mental Health Coordinating Council, 2016).

For support workers who have little or no contact with their colleagues and often do not receive supervision, networks can offer opportunities for them to have contact with peers, engage in group supervision and reflection, discuss practice issues, and offer mutual support.

Evaluation of Recovery-Oriented Practice

Research and evaluation activities are important factors in developing the ongoing evidence base for practices, models, and programs and to drive quality improvement in services. Several recovery outcome measures have been developed to evaluate the recovery-orientation of service delivery or personal recovery outcomes of consumers. There is also a tension in practice between recognising recovery as a lived experience with its own unique features for each individual and the use of such measures. Hence, while these measures may not necessarily ensure recovery oriented ways of working with individuals, they are important for monitoring and evaluating the extent to which organisational changes in services and practices occur.

Examples of recovery oriented measures that have been developed include:

- The Recovery Enhancing Environment Measure (DREEM).
- The Recovery Assessment Scale (RAS).
- The Questionnaire about the Process of Recovery (QPR).
- The Recovery Star.
- The Recovery Oriented Systems Indicators Measure (ROSI).
- The Recovery Self-Assessment (RSA).
- The Recovery Oriented Practices Index (ROPI).
- The Recovery Promotion Fidelity Scale (RPFS).

A review of many of these measures and their use can be found in the Measuring Recovery in Australian Specialised Mental Health Services: a status report (Mental Health Information Strategy Standing Committee, 2015). Several of these measures were developed for, and have been used in studies evaluating recovery oriented practices, such as Bird et al. (2018), Hall et al. (2018) and Meadows et al. (2019). The PULSAR study (Meadows et al. (2019) also identified that consideration needs to be given to their cross-cultural relevance when using a mental health recovery questionnaire, such as the QPR, and its appropriateness to the CALD community (Kakuma et al., unpublished). Kakuma et al. (unpublished) found that there were different conceptualisations of personal recovery among different CALD communities.

Further information:

Measuring Recovery in Australian Specialised Mental Health services – Report

Conclusion

This report has explored how to address the barriers and workforce-related issues impacting on effective recovery-oriented practice for NDIS participants with psychosocial disability. It has identified the potential benefits and numerous challenges associated with adopting the knowledge base, values and mission, skills, and measurable indicators that both the individual members of the NDIS workforce and the organisations that employ them will need to adopt to meet the aspiration of embedding recovery-oriented practice. It is hoped that this work will contribute to guiding the development of a consistent national picture of the recovery-oriented capabilities required for psychosocial disability support workers.

Glossary of Key Terms

The terminology used in this report has been selected with care to convey respect for the people and groups are referenced in this report. In the report the terminology used is preferred by the NDIS or the Project Reference Group (PRG). Notably, many terms can have multiple definitions or meanings depending on in which sector or in which context they are used. Academic disciplines, stakeholder groups and governing bodies use different terminology over time. The preferred terminology, particularly for specific concepts, has been selected with reference to the literature, where it may differ from the preferred terms.

Capability

"Capabilities for recovery-oriented practice and service delivery encompass underlying core principles, values, knowledge, attitudes and behaviours, skills and abilities. Individuals, teams and organisations need these capabilities in order to support people with mental health issues to live a meaningful and contributing life in their community of choice. Attaining and strengthening these capabilities is an ongoing process that takes time and commitment from leaders, professionals, staff and volunteers in mental health service provision" (Australian Government Department of Health, 2013b, p. 5).

Community Participation

Community participation refers to having involvement in the everyday world of activities, relationships, community groups or organisations as part of communities of one's choosing – such as neighbourhoods, workplaces, educational and recreational settings, civic groups and so on – rather than in activities that substitute for community involvement (Baron, 2018; Fossey, 2009). In this sense, community participation is intertwined with, and central to, experiencing social inclusion.

Consumer

In the mental health context, consumer refers to people who use mental health services, or who may in the future.

Culturally and Linguistically Diverse (CALD) Communities

Commonly used to describe people living in Australia from different countries across the world, who speak languages other than English and have diverse cultural backgrounds and/or religious beliefs.

Intersectionality

Intersectionality is a lens which showcases how systems and structures can interact to affect the recovery and general wellbeing of individuals and groups. A participant can have numerous social identities at the same time. It is important for a worker to consider as part of their holistic approach all of a person's social identities at the same time. This action and lens can assist a worker and participant to see and understand how privilege, power, and oppression shape a person's sense of power, resilience, and wellbeing (Department of Health and Human Services, 2020).

LGBTIQ+

Lesbian, gay, bisexual, transgender, intersex, queer (LGBTIQ+) is the acronym used to indicate sexuality and gender diverse identity groups. LGBTIQ+ "is an umbrella term that refers collectively to an array of distinct sexual orientation and gender identity groups, each with their own unique experiences and health needs" (Mink et al., 2014, p. 504).

Lived Experience

Lived experience refers to "the experience people have of their own or others' mental health issues, emotional distress or mental illness, and of living with, and recovering from, the impacts and consequences of their own or others' mental health issues, emotional distress or mental illness" (Australian Government Department of Health, 2013b, p. 33).

Mental Health Condition

Mental health condition is the term used by the NDIS (NDIS, 2018, p. 3) to refer to mental health experiences which may interfere with a person's functioning or ability to lead a happy and easy life.

Participant

In this report, participant refers to consumers who are enrolled in the NDIS, as opposed to people who have engaged in a research project (research participant). Participant is an NDIS-specific term, "a person becomes a participant in the NDIS once the NDIA determines they satisfy the access criteria" (NDIS, 2018, p. 4).

Person Centred Care

Person-centred care is an approach to recovery that focuses on the strengths, uniqueness, and dignity of the individual. Practitioners and consumers work in an equal collaborative partnership to develop self-directed recovery goals, and practitioners support the independence of consumers through responsibility and accountability of people to their own recovery goals. (Also referred to as: Person-centred support, consumer centred care, consumer directed care (CDC), and person led care and support)

Psychosocial Disability

Psychosocial disability has been defined by the National Mental Health Consumer & Carer Forum (2011, p. 16) as "the disability experience of people with impairments and participation restrictions related to mental health conditions".

Recovery

There is no single description of recovery because it is by nature a deeply personal lived experience. As stated in Australia's National Framework for Recovery-oriented Services, "the concept of recovery was conceived by, and for, people living with mental health issues to describe their own experiences and journeys, and to affirm personal identity beyond the constraints of their diagnoses." (Australian Government Department of Health, 2013a, p. 3). Within this framework, recovery is also described as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (Australian Government Department of Health, 2013b, p. 17).

Furthermore, recovery involves "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (SAMHSA , 2012, p.3). Thus, recovery emerges from hope; is person-driven; occurs via many pathways; is supported by peers and allies; occurs through relationships and social networks; is supported by addressing trauma; involves individual, family and community strengths and responsibility; and is based on respect (SAMHSA, 2012).

Recovery-Oriented Practice

Recovery-oriented practice encapsulates principles and frameworks for practitioners and providers to implement in the delivery of services that promote and support the recovery of participants (Australian Government Department of Health, 2013a).

Social Determinants of Health and Wellbeing

Social determinants of health and wellbeing are the circumstances in a society that influence health and wellbeing, such as housing, transport, education, healthcare, employment, discrimination, stigma, social exclusion, and income security. These circumstances are in turn driven by wider economic and political forces. Adverse social environments can have a detrimental effect on mental health, and typically people with the lowest socioeconomic status experience the worst mental health outcomes.

Social Inclusion

Social inclusion is often not defined directly but understood as not being socially excluded. So, whereas social exclusion identifies a set of often interconnected conditions that contribute to people becoming marginalized in society (such as low income, unemployment, social isolation, discrimination, disability), social inclusion is linked to notions of belonging, connectedness, social ties and to conventions according full rights as citizens to all people (Sayce, 2000; The United Nations, 2006; Thornicroft, 2006). Inclusive communities therefore strive to ensure all individuals have equal opportunity to meaningfully participate in their communities, and value the diversity that this brings to the community (Salzer & Baron, 2016).

Workforce Capability

Workforce capability "describes the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery-oriented principles and provides guidance on tailoring recovery-oriented approaches to respond to the diversity of people with mental health issues, to people in different life circumstances and at different ages and stages of life" (Australian Government Department of Health, 2013b, p. 16).

Acronyms and Abbreviations

Community Connectors	NDIS Psychosocial Community Connectors Program
CRM	Collaborative Recovery Model
D2DL	Day to Day Living
DSS	Department of Social Services
ImROC	Implementing Recovery through Organisational Change
LAC	Local Area Coordinator/s
MHA	Mental Health Australia
MHV	Mental Health Victoria
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDIS Commission	NDIS Quality and Safeguards Commission
PHaMs	Personal Helpers and Mentors
PIR	Partners in Recovery
PPP	PulteneyTown People's Project
PRG	Project Reference Group
PULSAR	The Principles Unite Local Services Assisting Recovery
RCVMHS	Royal Commission into Victoria's Mental Health System
Recovery Coach	Psychosocial Recovery Coach
The Current Landscape	The Current Landscape – Good practice in recovery-oriented psychosocial disability support: Stage One Report
The Future Horizon	The Future Horizon – Good practice in recovery-oriented psychosocial disability support: Stage Two Report

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Appendix: Recovery Oriented Psychosocial Disability Support Workforce Capabilities

Please note:

These capabilities are from the report section Recovery Oriented Psychosocial Disability Support Workforce Capabilities (p. 36). Please refer to this section for further detail and descriptions of each capability domain. Notably, there is significant overlap between capabilities in the domains, which reflects the ways in which best practice recovery-oriented psychosocial disability support (ROPDS) has emerged from multiple sources. For example, in the person-centred approach, workers utilise supported decision making to assist participants to make meaningful choices. This is also reflected in the recovery oriented approach, which empowers participants to engage in choice and decision making by providing information and supports.

Person-Centred	Supporting Personal Recovery	Social Inclusion and Social Determinants	Collaboration, Communication and Coordination
Knowledge base			
Having knowledge and understanding of:			
Psychosocial disability, complex support needs, disability, and the rights of people with disability	Recovery and its components: hope, personal responsibility, identity, education, advocacy, and peer support	Structural impacts on recovery	Service systems and resources including mental health, health disability and other key areas
Shared decision making and supported decision making including the roles of decision-supporters	Individual experiences of recovery	Social and relational recovery and the importance of connections	Local services and supports available and their inclusion criteria
Human rights	Autonomy, self-determination, resilience, and choice and control	Social inclusion and effects of social exclusion on mental health	Vision, goals, and aspirations for recovery-oriented practice
Cultural safety	Strengths-based approaches to all elements of working with participants	Social determinants of mental health	The roles and responsibilities of other team members in supporting recovery
Frameworks and information for working with diverse communities	Emphasis on wellbeing and the person's own goals and strengths	Stigma and discrimination	Information sharing and collaboration with other services
Intersectionality	Collaborative approaches and practice including the importance of exploring values and preferences	Strengths-based approach	Present and convey important information in a manner that enables participants, families, and others to understand
Interrelated domains of wellbeing and recovery: clinical, functional, physical and social	Reflective practice	Cultural determinants of mental health	Sharing information requires informed choice, and enabling participants to have control
Support needs may span and interplay between physical health, mental health, disability and coexisting conditions	Individual experiences of disability can influence the support a person may need to make an informed choice	Connection to Culture and Country for Aboriginal and Torres Strait Islander peoples	Peer workforce
Trauma-informed approach	Supporting the person to make their own decisions	Impact of social determinants on marginalised communities	Families, friends and carers, importance and role
Person in environment	Mental health consumer advocacy and carer groups	Social justice issues, human rights, and service systems, to advocate for social justice	Dignity of risk and the importance positive risk-taking

Person-Centred	Supporting Personal Recovery	Social Inclusion and Social Determinants	Collaboration, Communication and Coordination
Values and Attitudes			
Having respect for and valuing of lived experience	Respecting participants' choices, values, and wishes	Respecting the unique experiences participants may have due to the role of social determinants	Being open to continuing to learn, developing knowledge, and skills
Valuing and approaching participants as individuals	Respecting participants' right to self-determination	Willingness to explore a range of domains such as housing and employment etc., in a respectful manner	Being open to working collaboratively
View the participant and their life situation holistically	Respecting and supporting participants' decision-making capabilities	Awareness of focusing on strengths and abilities while also acknowledging potential barriers and limitations	Being open to new ideas and creative solutions to challenges
Respecting participants' choices, values, and wishes	Respecting and valuing lived experience	Awareness of worker's own background and biases and the implications for working with participants	Being respectful of differing opinions and solutions
Respecting participants' rights to self-determination	Valuing collaborating relationships with participants to work and learn from each other as well as from those important support people in a participant's life	Willingness to learn from participants, their families, and other supporters, as well as different communities and cultures	Being willing to seek advice, supervision, or the opinions of others
Respecting and supporting participants' decision making capabilities	Being open to participants' perspectives and opinions as well as being flexible and adaptable to their changing needs and wants		Having an awareness of the boundaries and limitations of your role and that of others
Reflecting on one's journey as a support worker and how one's personal bias and experiences may impact on practice	Being open to participants' own understandings and definitions of their challenges		Seeking out learning opportunities
			Showing willingness and readiness to reflect on practice and adapt as needed

Person-Centred	Supporting Personal Recovery	Social Inclusion and Social Determinants	Collaboration, Communication and Coordination
Skills and Measurable indicators			
Communicating effectively using plain language	Learning and acknowledging participants' values, beliefs, treatment, support preferences, and goals and aspirations	Discussing social determinants and structural barriers with participants, identify the areas of impact	Assisting participants to access the services, supports, and care they need
Engaging with informal supports and resources: relationships, activities and education	Conveying belief in participants' capacity	Working inclusively with participants' family, friends, and/or carers	Providing information and referral
Acknowledging participants' family, carers, and informal supports	Working in partnership and collaboratively with participants	Identifying existing strengths and connections that can be built upon	Sharing information in a manner that is understandable to the participant and other relevant parties
Working in a collaborative manner with the person's supports	Use of micro communication skills to support recovery	Advocating for participants' rights and access to services	Working collaboratively with other services and supports
Coordinating and collaborating with a range of relevant services beyond the mental health system	Active listening that conveys respect	Supporting participants to connect with their communities	Providing information that supports choice and control
Gathering information to understand behaviours, strengths, challenges, interests, triggers and preferences	Engage participant in decision making	Considering and discussing whether current supports and service arrangements enable participants' existing relationships to be maintained	Seeking out and connecting with people with lived experience and the peer workforce
Approaching participants in a manner that sees them as individuals, Thinking flexibly and tailors interventions to the person	Supporting people to identify personal aspirations, goals and intrinsic motivators	Discussing social and relational elements of participants' lives	Seeking out and connecting with elders, interpreters, community leaders, cultural advisers etc.
Engaging in supported decision making where appropriate	Engaging honestly and managing conflict	Learning who the important people are in a participant's life	Managing conflict and different opinions
Work with consideration of the person in their environment	Supporting participants to build self-advocacy skills	Considering participants preferences and complex family relationships	Advocating for the needs and goals of participants
Be responsive to cultural needs	Actively informing participants of their rights	Understanding and supporting connections and relationships	Advocating for a recovery focus

Celebrating strengths and successes	Engaging in reflective practice	Supporting participants and families to identify what recovery means for them	Being aware of own personal bias, values, and experiences in shaping opinions
Communicating and demonstrating optimism and belief in participants' abilities	Using a strengths-based approach	Encouraging participants to better understand the role and importance of their connections,	Creating opportunities and space for participants to feel they are safe to express their feelings, aspirations, and goals
Promoting and assisting with effective coping strategies if necessary	Building trust and reciprocity with participants	Support goal setting in each of the following domains: housing, employment, education, spiritual/religious; and physical activity/leisure/recreation	Provide opportunities for positive risk taking
Identify the physical health needs and goals of participants	Sharing aspects of one's own life experience where appropriate for recovery	Openly exploring with participants ways in which goals in these areas may be achieved	Communicating openly, honestly and transparently
Engaging in preventative health activities where appropriate	Fostering participants' resilience	Encouraging and supporting the building of participants' capacity to engage with others	Discussing and learning from previous challenges: what worked, and what continued to be difficult
	Promoting independence and informed choice	Identifying and discussing the role of family, friends, or others in assisting in building capacity	Discussing openly the potential growth that positive risk-taking may support, as well as the potential for setbacks and challenges
	Enabling formal and informal supports in decision making	Supporting and demonstrating interpersonal skills	Assessing and monitoring risks that may be required but remaining open and transparent
	Acknowledging and minimising power differences in the relationship	Encouraging and supporting participants in developing skills that assist with social and relational elements of recovery	Utilising a team approach where appropriate
	Fostering participants' belief in their capacity for growth and abilities	Learning and supporting the discovery of meaningful activities	
		Engaging in supervision and reflective practice	