Co-Designing Service Quality at the JMHSS

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Neami National
Improving Mental Health
and Wellbeing

Acknowledgements

This report gathers together and presents information obtained from consumers, staff and management during the process of engaging in quality improvement working group activities at the JMHSS.

Thank you to each of the members for your openness, enthusiasm and commitment to consider these topics and sharing your ideas under the banner of ensuring the JMHSS service is 'improving mental health and wellbeing outcomes for consumers'.

And a special thanks to Catherine Atoms and Margaret Kitto for their role in organising and co-facilitating the working group activities.

We acknowledge Aboriginal and/or Torres Strait Islander peoples and communities as the Traditional Custodians of the land we work on and pay our respects to Elders past, present and emerging. We recognise that their sovereignty was never ceded.

Neami is committed to cultivating inclusive environments for staff, consumers and carers. We celebrate, value and include people of all backgrounds, genders, sexualities, cultures, bodies and abilities.

Contents

Background

In this report we share findings from a quality review process at the Joondalup Mental Health Step-Up Step-Down (JMHSS) service.

Evidence from mental health service user crisis plans indicate that whilst some people would request hospitalisation during a mental health crisis many would prefer to draw on other alternatives[1].

In Australia, Step-Up Step-Down residential facilities (otherwise known as Prevention and Recovery Centres or PARC's) have emerged as an option that can meet consumers where they are at, either in terms of prevention, (thus minimising escalation of illness or need for acute care) or post hospital support to sustain and strengthen ones recovery and thus minimise the potential for readmission[2]. The Joondalup Mental Health Step-Up, Step-Down (JMHSS) service commenced operation in March 2013 as the first of its kind in Western Australia.

In 2017, Neami researchers partnered with University of Western Australia Research Fellow Dr Hanh Ngo to undertake an evaluation of the JMHSS service. A primary aim of the study was to assess the value and impact of the JMHSS to local health service systems and service user recovery and wellbeing outcomes. Dr Ngo contributed with an independent analysis of data obtained from consumers during the course of their stay at the JMHSS and hospital admissions data obtained from the Western Australian Data Linkage Branch (WA DLB).

Complementing this study an exploration of processes at the site and regional level that contribute or detract from successful service outcomes was also undertaken by members of two quality improvement working groups. This report presents findings from the working group activities.

Figure 1 (below), outlines the areas of focus for each of the working group meetings. Appendix A provides a figure demonstrating the link between this body of work to the wider JMHSS research project.

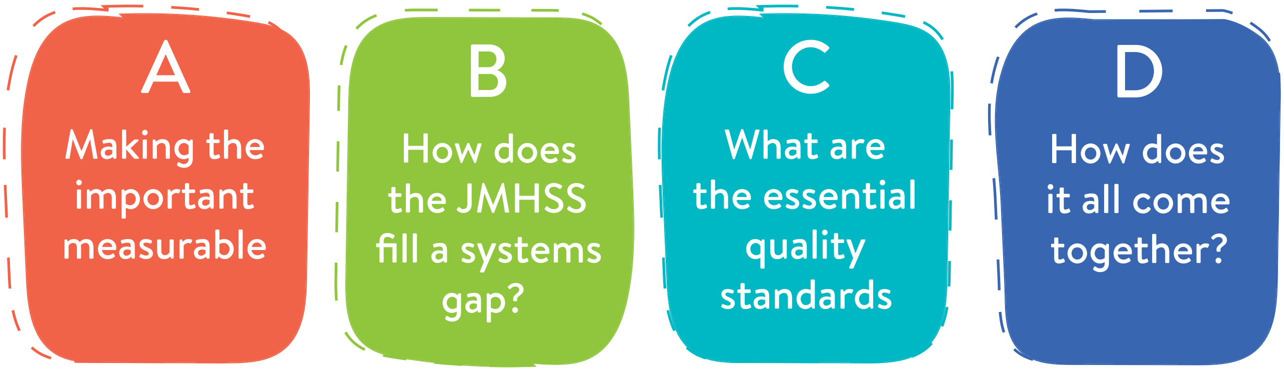


Figure 1

Co-designing Service Quality

An important component of the JMHSS evaluation involved the establishment of two quality improvement working groups. Led by principles of co-design, members across two groups undertook a collaborative inquiry process to review findings from the study and provide insights from experience and observation about areas of practice and process. Collaborative inquiry in this context refers to 'understanding and constructing meaning around experience for the purpose of enhancing practice'[3].

Participants were selected to include both consumer/user and service practitioner/provider expertise.

Working group members undertook pre-meeting reading, individual reflective work, group reflective activities and discussion. They also provided post meeting feedback summaries.

The goal was to identify areas of service practice that are important to maintain and strengthen and those that could be enhanced or modified.

Appendix B presents a reflection on the co-design process by Dianne Zanetti.

The illustration included below (figure 2) was produced by the Auckland Co-Design Lab and was seen by working group members to reflect processes enacted during the activities for this project.

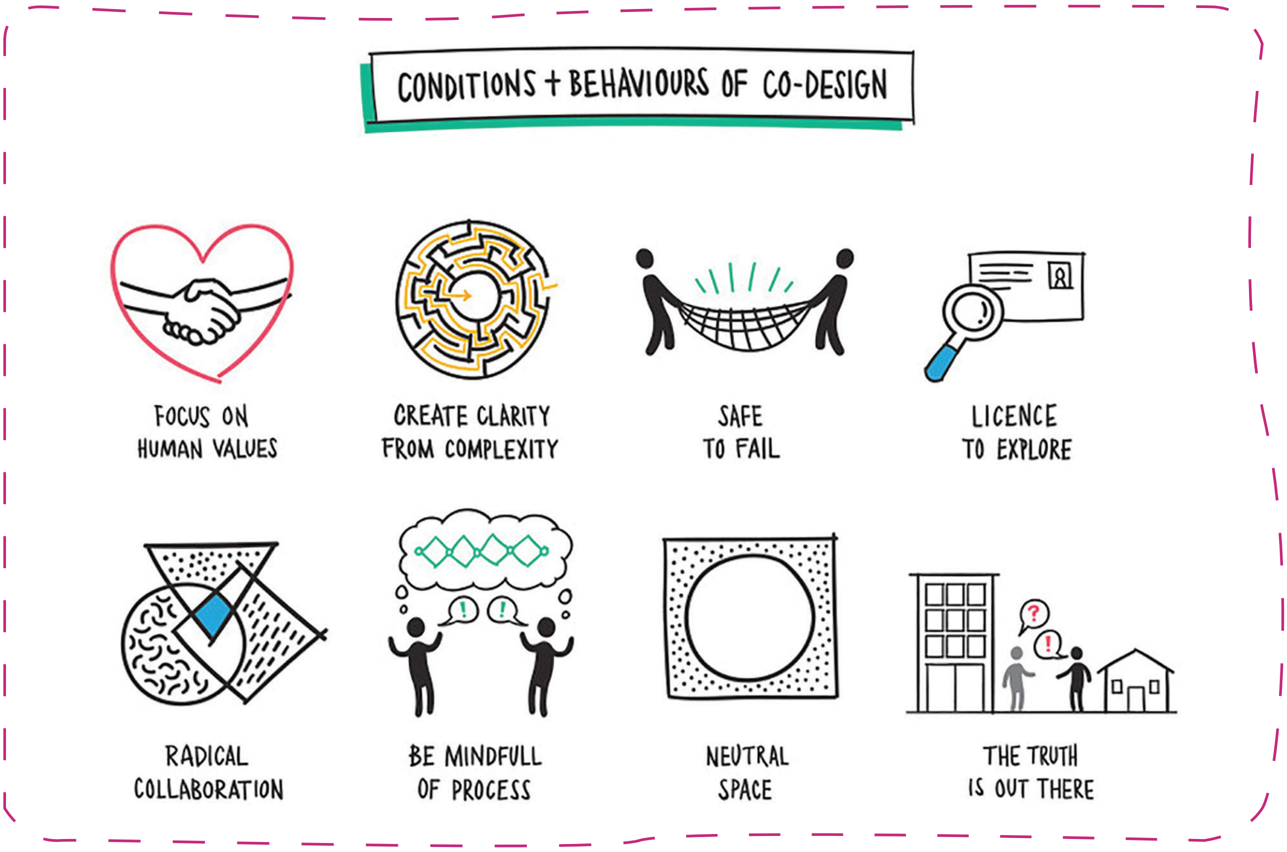
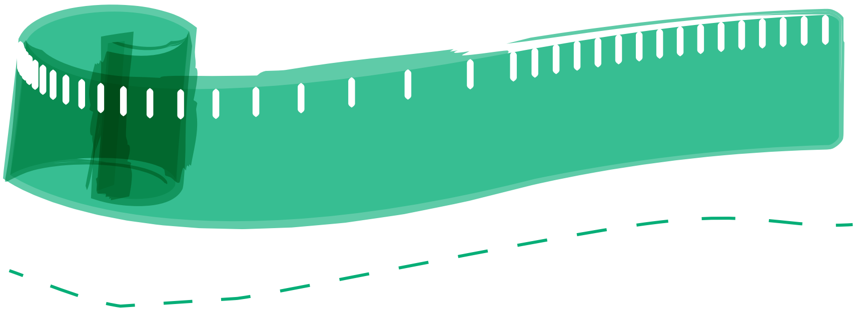


Figure 2 - Illustration courtesy of Auckland Co-Design Lab

Measuring Recovery & Wellbeing



What were we trying to find out?

The objective for this component was to review the measurement tools used at the JMHSS and explore their fit in terms of being able to assess what is going on for a person to inform service support planning and to measure recovery, wellbeing and/or quality of life gains for people who had spent time in the service. The objective was framed by statistician Robert McNamara's advice;

> *"the challenge is to make the important measurable, not the measurable important".*

Working group members were reminded that measures are utilised for a variety of purposes by services and that decisions about what tools to use had to take into account what may be useful for consumers, useful for services in planning program and approach, and useful for funders to make comparative evaluations across different types of services [4,5]. In addition, decisions about which measures also require consideration about whether a measure is easy to access, practical to use, and is psychometrically reliable and valid [4,5].

How did we go about it?

Group members undertook a reflective exercise to generate essential indicators of recovery and wellbeing as personally experienced or observed in others. After sorting indicators into like groups members compared the indicators to questions within the K10, GSES and WSAS.

Members provided feedback about which items were a good match, which items were missing and feedback about the overall measures and individual items in the measures more generally. Members also reviewed results from an independent analysis of K10, GSES and WSAS data obtained from consumers who used the JMHSS service between July 2014 and June 2016.

What did we find?

1. Indicators of recovery and wellbeing

Indicators for recovery and wellbeing were seen best as categorised as either internal or external. The table on the following page presents the indicators.

The indicators were perceived as forming a comprehensive list of thoughts, feelings and behaviours and alignment with knowledge and evidence from recovery, positive psychology and wellbeing literature was noted.

They are framed in strengths-based language thus allowing a person to assess where they stand in relation to these.

The process of having people consider 'indicators' in this way may be a constructive way of getting people to reflect and focus attention on how they want to be and by implication what they need to be doing or have in place to get there.

A. INTERNAL INDICATORS

i.e. things a person might notice about themselves but won't necessarily be noticed by someone else.

I am feeling:

- Safe
- Hopeful and optimistic
- Interest (in participating in life and social activities)
- Motivated (I want to do things)
- Confident (I can do things)
- Physically energetic (I have the energy to do things)
- Connected (to life and others).

I am able to

- Experience positive emotions
- Feel pleasure, joy and gratitude
- Be present (not dissociating or less often caught up in unhelpful thoughts)
- Refrain from judgement of self and others
- Be compassionate and empathic to self and others
- Give and receive love and intimacy
- Interact positively in social situations
- Respond resiliently to (or cope with) setbacks (look for solutions, alternative strategies)
- Balance work, pleasure, play and rest.
- Maintain my wellbeing supports.

I have a sense of:

- Self-acceptance, self-esteem and self-love
- Centeredness and authenticity (sense of self and how act in the world feels authentic and true to own values)
- Composure i.e. regulating emotions, peaceful demeanour, contentment
- Belonging, connection and value to others
- Being open to new experiences and learning
- Mastery and achievement
- Making gains and building strength
- Thriving rather than surviving.

My thoughts are

- Hopeful and optimistic
- Forgiving and gracious
- Affirming and validating
- Expansive in their approach to resolving difficulties and coming up with solutions to meet challenges.

B. EXTERNAL INDICATORS

i.e. things a person might notice they are doing or attending to and may be also be noticeable to others.

- I am keeping on top of my day to day administrative responsibilities e.g. mail, phone calls, budgeting, banking, bill payment, scheduling appointments
- I am undertaking activities that support my physical health and wellbeing e.g. eating healthy meals, exercising regularly
- I engage in activities that specifically support my mental health, wellbeing, and resilience e.g. taking medication, do yoga
- I am maintaining daily self-care e.g. showering, dressing for the day
- I undertake daily routines that keep my home and living space organised, functional and pleasant
- I have a network of resources and supports to draw on
- I am using positive social skills in my interactions with other e.g. listening, showing empathy, regulating emotions, being appropriately assertive
- I am getting out and engaging in activities or hobbies for interest and pleasure
- I am getting on with other people
- I am undertaking responsibilities that contribute to my family/community/society
- I am engaged in paid or unpaid work activities
- My posture and body language reflect energy, strength and confidence
- I am achieving goals that are meaningful and/or support my wellbeing.

2. K10, GSES, WSAS review

The three measurement tools were seen to broadly reflect three areas that are important to assess i.e.

1. How a person is feeling,
2. Confidence/capacity to manage,
3. Impact on everyday functioning.

However, there was a mismatch between the identified recovery and wellbeing indicators and the items covered in the K10, GSES and WSAS with a significant number of domains considered important missing.

Moreover, significant concerns were raised about the language used in the measures, implicit assumptions about the nature of illness, the lack of ability for consumers to provide context for responses, and lack of explanation regarding purpose, process and limitations. Appendix C provides a copy of the K10, GSES & WSAS.

Research literature indicates that each of the measures presently used at the JMHSS have sound psychometric properties, are recommended for routine use in Australia and are easily accessible [4 5 6 7 8 9].

Key Learning:

"The language we see, use and hear frames our perceptions, feelings and thoughts. If you are reading questions about feeling hopeless, unworthy and sad, that is where your attention is drawn to, and ultimately what you will notice you experience…"

There is also increasing recognition for a gap between the mandates for mental health services to become recovery-oriented and present measurement practices in Australia[10 11].

Measures proposed for routine use in Australia are for the most part designed by professionals and predominantly focus on symptoms and deficits[7 12]. Mental health consumers have advocated for a broader understanding of recovery and pointed out that traditional clinical measures are constructed to a biomedical understanding of illness and are too disability-oriented[10 12 13]. A recovery-orientation calls for the inclusion of strengths and wellbeing based domains in assessment and measurement practices[10].

The Siggins Miller Report authors conclude that there is an acute need in routine measurement practices for the development of a brief measure relating to coping, resilience, recovery, empowerment, hope, and similar consumer-identified domains.

3. K10, GSES and WSAS outcomes data review

Working group members reviewed findings from an independent analysis of K10, GSES and WSAS data obtained from consumers who used the JMHSS service between July 2014 and June 2016. The results indicated that receipt of JMHSS services was associated with significant improvement in the people's psychological wellbeing (i.e., reduced distress as measured by K10), general sense of self-efficacy, and work and social adjustment.

Group members were of the opinion that if you were evaluating outcomes for consumers or judging the success of a service based on K10, GSES & WSAS data you would miss out on evidence for a lot of the gains that actually happen for people in their time spent at the JMHSS.

Recommendations

Short term goals

When using measures with consumers:

- Provide an introduction and explanation of purpose (e.g. why using, how info will be used), process (e.g. how long it will take, options, confidentiality) and limitations (e.g. in usefulness, breadth).
- Provide opportunity for a consumer to provide context and ask them if there is anything they haven't been asked about that they would like us to know.
- Provide opportunities for consumers to talk about (and formulate) their own 'indicators'

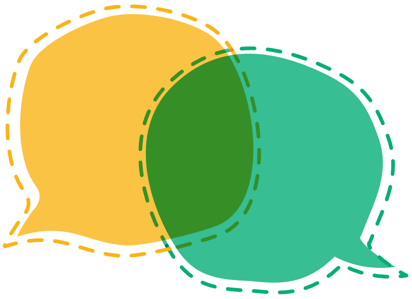
Longer term goals

- Look for alternatives to improve or replace/improve existing measures.
- Seek out opportunities to develop the 'indicators of recovery and wellbeing' to use as a reflective process or measure.

Conclusion

The working group findings in this component are supported by existing research literature and highlight the disparity between policy directives for mental health services to become recovery-oriented and present measurement practices[10 11]. Routine measurement is useful for funding providers to compare outcomes across service types and results of measurement data analysed for this study demonstrate positive changes for consumers attending the JMHSS. However, at present the measures routinely used in Australia are predominantly constructed by professionals and remain negative in nature i.e. related to illness, symptoms and low functioning, rather than growth based or measures of wellbeing[7 12].

Mental health consumers view recovery as vitally linked to a meaningful life[12] and prioritise outcome domains such as coping, resilience, recovery, empowerment and hope[7 13]. For mental health services to support mental health and wellbeing outcomes a broader use of measurement that aligns with dimensions that are important to consumers recovery is paramount[10]. The set of recovery and wellbeing indicators that were generated by working group members in this review may help to inform such endeavours.



How does the JMHSS fill a systems gap?

What were we trying to find out?

The objective for this component was to understand how the JMHSS is experienced as filling a systems gap and identify areas for strengthening.

What did we find?

1. Interpretation of hospital usage data findings

Working group members reviewed findings from an independent analysis of hospital admission data for 267 people who had utilised the JMHSS service along with a comparison of data for a matched cohort of people who had not accessed the JMHSS.

Findings revealed that people had a reduction in admissions to hospital, reduction in length of time spent in hospital and reduced risk of being admitted to hospital, after spending time in the JMHSS. Working group interpretation and comments in response to these results included:

- After spending time in the JMHSS people may be more likely to tackle aspects of physical health that have previously been neglected including hospital admissions to address these. This may happen because people have stabilised their mental health and/or they have been encouraged by the JMHSS holistic approach to health.
- The JMHSS assists with keeping hospital admissions and stays to a minimum as Neami staff and programs teach consumers life skills that can be used to recover and to stay well for longer.
- It was noted that for people who hadn't accessed the JMHSS, emergency department presentations increased overtime, indicating that without the type of support the JMHSS provides things can get worse.

2. The role of the JMHSS service in filling mental health system gaps

Key themes identified by working group members for how the JMHSS was perceived as filling a gap in the WA mental health service system were related to:

1. Its role as an intermediary alternative between having to go to hospital and staying at home with community based support, and
2. Components of the service approach not widely available in other service contexts.

Figure 3 (below) has been designed to represent working group member feedback.

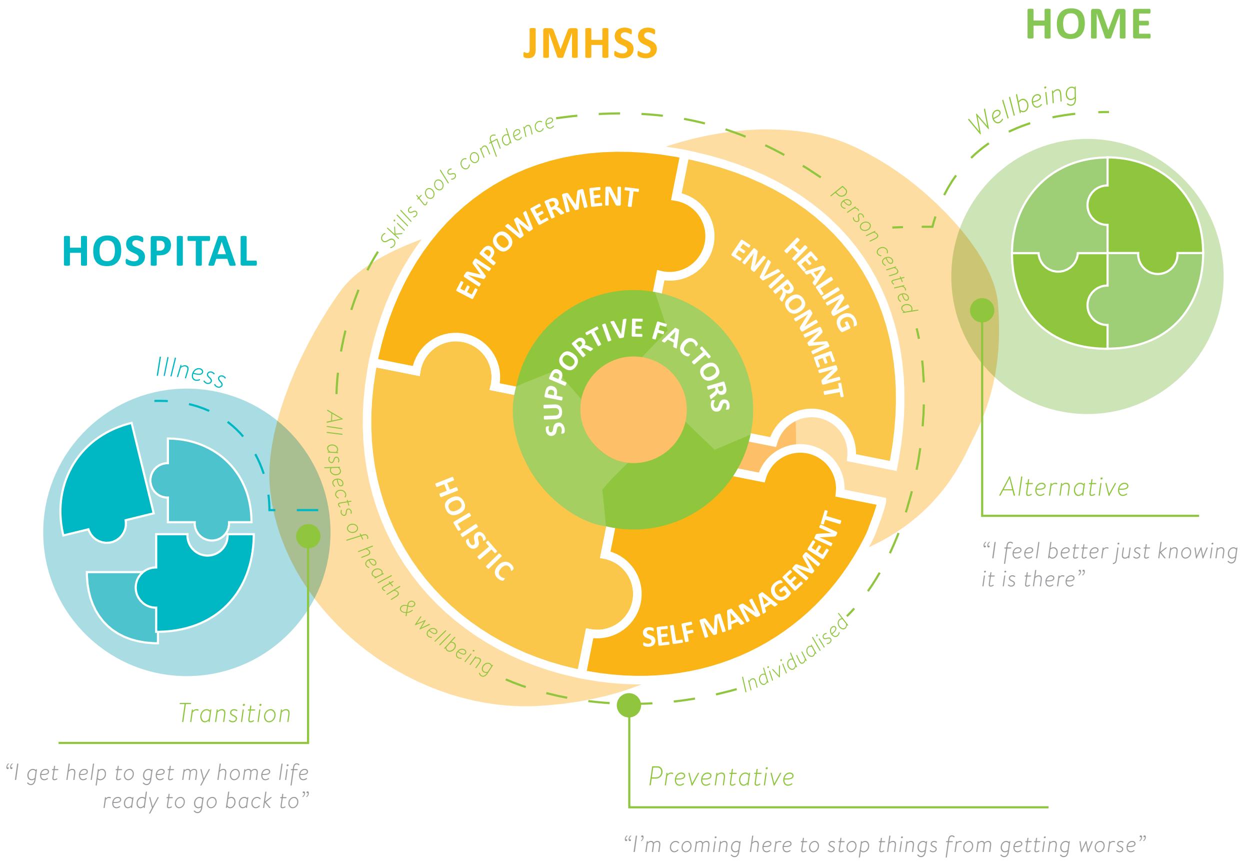
The following working group member comments embody the themes and rationale for how the JMHSS is experienced as filling a mental health service system gap.

Preventative

"Without the JMHSS, consumers would need to get worse to qualify for a bed in a psychiatric facility and would therefore have a longer recovery period as in-patients".

"If getting into hospital when things were really critical was the only option... well by that time relationships are.., you might have lost your job... there are a whole lot of different types of costs to people's lives that are hard to quantify".

"When I am coming here to the JMHSS it is a preventative thing, to stop myself from having to go to hospital. It's worked to prevent hospital admissions for me but it's also worked when I come out of hospital as a step down".



"I get help to get my home life ready to go back to"

"I feel better just knowing it is there"

"I'm coming here to stop things from getting worse"

Figure 3 - illustration courtesy of Cristal Hall

Having an alternative

"The thought of going to hospital can make you worse, because a hospital admission is very scary thing. Neami is almost like a safety net. Because I know that it is here, that I know that I can come and do it - I don't need to".

*"I've got that safety net in place and **I feel better just knowing it is there**".*

Supportive of self-management, independence & personal empowerment

"The JMHSS supports you to take responsibility for your own wellbeing - you have independence here, whereas in hospital everything happens for you, you do nothing for yourself, your meals arrive, the medicine arrives, you don't actually have responsibility for yourself, what's good about Neami is you do have responsibility... I think that helps you take that step back to reality, whereas hospital is a very abnormal place to be really".

"Having the Optimal Health Program (OHP) care plan helps you to get the help you need before you get to the point of needing a hospital admission".

"It supports consumers to identify 'triggers', it goes through what to do when you are feeling a bit unwell, more unwell and even more.., and the steps you need to take at each of those points".

"A service like Neami can actually help people navigate the system more effectively - education of people to advocate for themselves, rights, ability to do stuff, able to voice your opinion, makes you a stronger person. One of the best things that Neami has done for me is that when I have presented at ED I am more aware of my rights and more aware that I should be treated in a respectful way".

Holistic

"JMHSS approach highlights that health is holistic, not purely chemical or medical and encourages consumers to address all aspects of their health and wellbeing".

"Staff are also more holistically skilled and different staff have different skill-sets and can offer you different knowledge and teachings".

"Rather than 'a medical intervention' to reduce 'symptoms' (effects) and then being sent home to deal with the crisis (often without the coping skills and resources required to manage it), people are given the help they need to access the resources, externally and internally, to resolve the situational crisis (cause) and heal themselves".

Environment is better equipped for healing

"Provides a space for human connection and understanding through peers".

"Consumers with PTSD who predominantly require a 'safe, supported environment' to deal with episodic PTSD fear-based symptoms, find the service approach provided at the JMHSS more relevant to their needs than in-patient and/or public health services".

"JMHSS is better equipped to deal with co-occuring physical disabilities – there is a disability-friendly unit (wheelchair access)".

"Disability aids, such as bed rails, toilet and showering equipment are available to consumers at all times".

Provides a transition from hospital to home and reduces risk of readmission to hospital

"When you become unwell there a lots of things you haven't been dealing with in the outside world and then you go home and all those things you need to do, even things like bill paying and things like that are still there. But when you come to the JMHSS they will actually help you to get your home life ready to go back to and I think that makes a huge difference".

"In hospital there isn't really any education or preparation or anything that is going to help you when you leave. It's just about stabilising you so you are stable enough and not a suicide risk".

"After a stay in Neami, consumers can use OHP skills to self-manage which can be all that's needed for a consumer to fully recover and/or to use as preventative tools in the future."

3. Gaps identified in the WA MH service system

Bed Availability & Wait List Times

“Shortage of beds in Mental Health Units and the tendency to prioritise beds based on whether a consumer is physically self-harming, experiencing suicide ideation or has attempted suicide”.

Trauma Informed Care & Setting

“There is as yet a lack of knowledge of trauma informed care or lack of systemic support to translate knowledge of trauma informed care into practice within ED and inpatient settings. Inpatient and ED settings are also not catered to trauma and PTSD experiences e.g. the bright lighting, shared bedrooms, and stimulating environment of ED and/or a hospital ward can make things worse”.

Physical disabilities and/or medical health needs in mental health settings

“There is a need to better accommodate and support people with physical disabilities and/or co-morbid physical health issues that require general rather than psychiatric nursing care within mental health service settings”.

Funding system

“Lack of continuity in funding for NGO’s can lead to service disruptions and diluting of impact for clients”.

Continuity of care: Lack of outpatient services and preventative care solutions

“To stop consumers experiencing the ‘revolving door’ of hospital to home and back again, additional forms of outpatient services (such as group therapy programs) with preventative and continuity of care measures need to be available”.

“At hospital, they say if you are feeling unwell just contact your GP; but it can take a couple of days. It can take up to 3 weeks to get into to see the community mental health service”.

Medication Continuity & Knowledge

“There is often a disconnect between what the hospital prescribes and then what a GP can prescribe. In hospital you can be put on a new medication, then GP’s can be reluctant to prescribe the same, as a GP has to prescribe according to diagnosis for person to receive PBS”.

“The hospital may prescribe you medications that are not on the PBS. You have to pay full price if you want your GP to prescribe these”. “The community-based clinic may be able to prescribe but only if you are linked into a clinic”.

Mental health knowledge in ED and regional hospital settings

“There is very limited MH expertise in smaller regional hospital settings. Having a mental health nurse should be a minimum”.

4. Gaps identified in Neami JMHSS service system

Each of the gaps identified below are presented for consideration as areas for strengthening and development.

Wait list times

The approximately 2 week from referral poses problems for people at risk of worsening mental health. It was thought that such a wait is significant when one is tackling a mental health crisis or looming mental health crisis. If waitlist times for JMHSS can be reduced, it will have a positive flow-on effect for all Western Australian mental health services.

Community knowledge about JMHSS

Whilst the JMHSS was seen as 'innovative' and doing a lot of things well it was recognised that people (consumers, community members, GPs and other mental health services) don't always know about what the JMHSS offers or how one can access the service. Knowledge about the JMHSS service is particularly limited in regional areas and JMHSS staff knowledge about service linkage options in regional areas is also limited. Maintaining knowledge of and relationships with less local services was recognised as challenging.

Inter service knowledge

Staff were considered to be generally quite knowledgeable about links to other services with some more knowledgeable than others and variability with how well links are established at times. It was thought that on the whole staff prepare people very well for their transition but some people may have extra vulnerabilities and may require additional transition care. Having a mental health plan that can be utilised between services was seen as important although challenges remain related to inconsistency between practitioners and services for attention to 'consumer developed' plans.

Medication knowledge

In line with the system gaps identified in relation to medication continuity (discussed above) it was thought that Neami staff may be able to play a greater role in supporting consumers to navigate the challenges and decisions involved in using medication.

Some additional areas for consideration at JMHSS:

- High staff turnover can affect continuity of care for returning consumers
- Staff skills and opportunities for consumer empowerment to be prioritised
- Stricter resident guidelines may increase respect amongst residents and place of healing
- Access to a range of alternative healing/ wellness activities e.g. yoga, nutrition, training and team sporting activities to build social skills.

Conclusion

The recent Australian national review of mental health programmes and services[1] illustrates the need to strengthen the sector's ability to provide services that keep people out of crisis, out of hospital, and enable them to lead contributing lives in the community[14]. Step-Up Step-Down residential facilities have emerged as an option within a system of mental health care to meet this need[2].

Whilst community-based care is often the preferred service option for many, for people requiring more direct support during episodes of illness a stepped approach can offer support, stabilisation and renewal[15]. There are a number of reasons cited for why people would choose alternatives to acute in-patient care if they were available[16]; including:

- desiring a less restrictive physical environment with access to exercise and activities,
- opportunities for person centred care including the recognition of individual circumstances and recovery needs, and
- lessening the experience of stigma that is often associated with having to be admitted to a psychiatric ward.

Working group member discussion and feedback confirmed the value of implementing the Step-Up Step-Down model in Australia. Members identified that as a preventative space, the JMHSS affords the opportunity for people to get help prior to a crisis, thus the need for acute care is reduced and illness losses can be minimised. Furthermore, as a recovery consolidation space - skills and confidence to manage at home are strengthened.

The practice approach and programs that consumers engage in during time spent at the JMHSS were also seen to provide a valuable point of difference within the local mental health service system. The JMHSS was seen as an intermediary space between hospital and home; that was both a place to heal and a place to gain the tools and readiness to re-engage with home and community.

Essential quality standards for the JMHSS

What were we trying to find out?

The objective for this component was to identify the 'quality standards' that most likely lead to positive consumer experiences and outcomes in the JMHSS.

How did we go about it?

Working group members undertook an individual reflective activity to identify perceptions of 'essential quality standards' for a service such as the JMHSS to uphold. Individual responses were categorised against the six Western Australia Mental Health Commission outcome statements along with a space for 'others' i.e. those that did not fit into the six. Feedback and consensus regarding what JMHSS were currently doing well, and where there were areas for improvement or development was obtained through group discussions.

1. What stands out as being done well and is therefore important to remain in focus?

Feedback indicated that there were a number of quality standards that stood out as being clearly implemented well in the JMHSS that have a valuable impact on consumer recovery and wellbeing outcomes. These were seen as being evident in:

1. The service approach, and as influencing
2. The nature of staff and consumer interactions, and
3. Service processes and program activities.

There was a cross over between key themes raised in this activity with those raised under the topic of 'how does the JMHSS fill a systems gap?' In particular, aspects related to developing skills in self-management and the holistic approach at the JMHSS, were also raised as being stand out quality standards that the JMHSS implements well.

The JMHSS approach is experienced as:

Person Centred

“What works well at the JMHSS site is that it is person centred care. That’s what you do here. It’s definitely centred on the consumer. It’s not centred on the staff... it’s very much centred on you. I felt that everything that happens here was about me and not about the staff. When you are in hospital it is a very different way around. Things happen TO you in the hospital whereas things happen very much the other way around here. That is what Neami does very best. It’s person, people centred”.

Holistic

“Consumers are encouraged to address all aspects of their health and wellbeing”.

Individualised

“The care is centred around you, you have your own folder your own plan, the plan is about you, your plan is not the same as somebody else’s plan, it’s all about your goals, your aspirations, what you want to achieve. Everybody hasn’t got the same thing written on theirs - which I think is very important”.

Empowering

“I was in control of what happened to me here and it actually made a huge difference to the way I felt and the way I felt much more in control of my mental health and then I was much more able to deal with my mental health and make steps towards going home”.

A place to build self-management skills and confidence

“Here you are given the tools to actually be able to deal with the outside world and that’s what you need”.

Continuously Improving

“Neami is not just resting on what is good but thinking about you can do to improve”.

Interactions between staff and consumers are experienced as:

Trusting

“I’ve had contact with a large number of agencies that work with people with mental illness and there is nowhere that I have quite the same level of trust that I have with staff members at Neami. Many of us (consumers) have never had that anywhere”.

Equal

“I feel more like an equal with the staff, I don’t feel like they look down or treat me as less than them and that’s why you feel you can trust them”.

Respectful

“Through the hospital system I get this idea that they see themselves as superior... and we are treated like we are inferior - Like, the doctor said this, so therefore you have to do it, you know, because he’s god, you know”.

Accepting

“There is no judgement, people here don’t judge, there is no preconceived ideas about people, about what your mental illness is or what you’ve come in with”.

Welcoming

“I haven’t been in this facility for over a year, but even when I came through the door here (today) I feel safe and welcome. I get that feeling as I come through the door”.

Relatedness

“Staff are prepared to share a little bit of themselves and you know if you want someone to share something about themselves with you, your preparedness to share a bit of yourself is really important. Staff do tend to remember you too”.

Caring

“It’s not the big things, it’s just the little things, that I feel like they care about me as a person, and that makes me trust them”.

2. What are areas for strengthening and development?

Wait list time

"I'd like to see a shorter time from when you get referred, sometime it can be as long as a two week wait and when you are having a mental health crisis, two weeks is a really long time". "And in that time you can go downhill, it can make your stay longer".

"Often when I am coming here it is a preventative thing, to stop myself from having to go to hospital and that delay can mean going to hospital".

Attention to arrival, introduction, welcome process, people orientation, fitting in

"It's really hard to walk into a room, when you are unwell, meeting new people is really difficult... to get that people introduction is important. The first time, I was so frightened, you do get shown around the facility and people, but if new staff come on, you don't know who they are - you could easily forget, how daunting that could be for someone new to the service".

Facility Accessibility – complexity & disability friendly

"Staff to have disability awareness training and to understand what impact disabilities can have on mental health".

"There is a need to increase the number of disability suites at JMHSS (and parking bays), and to ensure there are sufficient disability aids available".

Some starting suggestions are included in Appendix D.

Program and conceptual flexibility

"Creating additional flexibility within the Optimal Health Program for people who have undertaken the program more than a couple of times, along with access to alternative therapeutic programs e.g. family/relationship skills building and alternative healing activities e.g. yoga".

"Recovery is encouraged but contextualised to recognise impact of trauma and episodic or enduring (non-recoverable) elements of illness or disability".

Carer Participation

"Strengthening involvement of significant others in relation to what is involved for consumers with a stay at JMHSS and what is in place on exit e.g. opportunities to hold joint meetings with consumer and significant others to clarify understanding of where person is at and additional supports and goals required for after exit".

Transition to home process - Time to heal, centre, and time to step out

"At the JMHSS you know you have 28 days. That's a good thing. It tends to follow a format e.g. Initial 2 or so weeks primarily about individual healing and self-management plans. After 14 or so days looking better, looking at discharge and all the services that are outside of that, wanting to ramp it up a bit, test yourself, different kind of activities to get a toe in the water".

Some thoughts to strengthen going home processes:

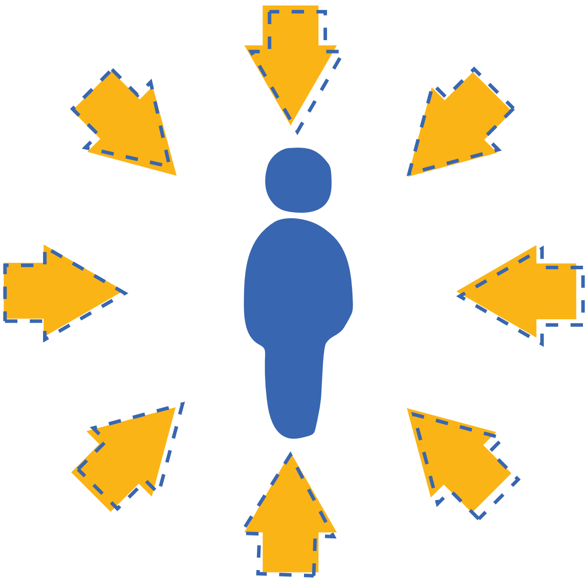
- Consider some kind of checklist process to ensure support linkages have been created.
- Check-in regarding the safety of the home environment and if required provide education about what is a safe environment.

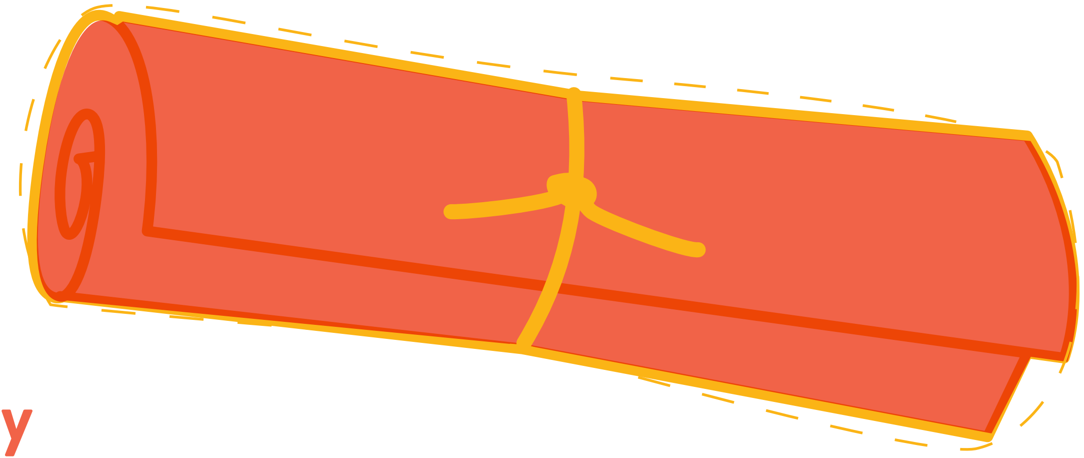
  "There are people who have been here who are in domestic violence situations and they are going back to it... sometimes some education on what is a safe home, especially with some of the young ones, they may not know that that is not normal."
- Strengthen follow-up calls to ensure services are in place and to confirm person has returned to a safe, positive environment.

Conclusion

Working group member insights from this component reflect dominant themes in recovery and wellbeing literature that propose that there is a need to prioritise attention to all aspects of health and wellbeing as opposed to illness and deficit as being the central focus[17 18 19 20]. Person centred care involves attending primarily to a person rather than seeing someone through a diagnosis or set of symptoms [21] and working group members identified this as a key strength of the JMHSS.

The strength of interactional aspects (between consumers and staff) to perceptions of 'quality' as seen in member feedback, reflect well established evidence for the importance of shifting what have traditionally positional roles between practitioners and consumers to those that are collaborative and purposefully relational [22]. Within this engagement style trust and safety can be established, strengths are recognised, and support is more likely to be wrapped around the unique needs, goals, and aspirations of the person seeking support [23 24]. Together the findings in this component provide both encouragement for the visibility and value of Neami's approach to service practice in the JMHSS and practical recommendations for how service quality can be strengthened in this setting.





Summary

In this paper we presented findings from a collaborative inquiry process undertaken at the Joondalup Mental Health Step-Up Step-Down (JMHSS) service in Western Australia. Directed by principles of co-design, members across two working groups provided insights from experience and observation about the service operations and processes at the JMHSS. This was undertaken to complement findings from an evaluation study undertaken by Neami researchers in partnership with Dr Hanh Ngo (University of Western Australia).

Measuring recovery and wellbeing

In the first component we gained a shared understanding of what is important when it comes to assessment and measurement tools and processes. The key learning point from this component was phrased as:

"The language we see, use and hear frames our perceptions, feelings and thoughts. If you are reading questions about feeling hopeless, unworthy and sad, that is where your attention is drawn to, and ultimately what you will notice you experience…"

Measures routinely used in mental health services were perceived as being predominantly illness and disability-oriented and negative in nature. The use of strengths and wellbeing based domains was seen as being important for orienting service users towards a potential positive future. Additional concerns were raised about implicit assumptions (biomedical framework) and a lack of opportunity for consumers to provide context for their personal situation when completing many of the assessment measures used in mental health services.

These perspectives are supported in wider literature and highlight the lag between policy directives for recovery-oriented service practices and measurement tools promoted for routine use in Australia [10 11]. The need for measures that reflect wellbeing domains important to consumers is recognised as critical to a systems orientation towards recovery [7 10].

Through an iterative reflective activity group members identified 32 indicators of recovery and wellbeing. Taken together these were seen as a comprehensive list of thoughts, feelings and behaviours; and their alignment with knowledge and evidence from recovery, positive psychology and wellbeing literature was noted. The set of indicators generated by group members may help to inform the development of assessment and measurement tools that promote attention to factors that support recovery. A number of practical recommendations to improve current assessment and measurement practices at the JMHSS site were provided.

The JMHSS in a system of health care

The JMHSS was perceived as a space between hospital and home. It was seen as both a preventative space, in that escalation of illness or need for acute care can be minimised; and a space to consolidate recovery after acute illness - where skills and confidence to manage at home can be strengthened.

It was also noted that the practice approach and programs offer a valuable point of difference within the existing mental health service system. In particular, Neami's holistic approach where service users "are encouraged to address all aspects of health and wellbeing" was seen as particularly valuable. Secondly, members indicated that the programs and environment are more amendable to healing and recovery as services users are given the opportunity to step out of their current situation whilst being enabled to step back in.

Quality standards at the JMHSS

Group members identified a number of quality standards that stood out as being implemented well in the JMHSS. These were seen as being evident in:

1. The Neami service approach,
2. Service processes and program activities,
3. And as influencing the nature of staff and consumer interactions.

Quality standards were considered to be enacted in the JMHSS approach through service delivery practices that were identified as person centred, holistic, individualised, empowering and continuously improving. Interactions between staff and consumers were identified as trusting, equal, respectful, accepting, welcoming, relational and caring.

Recommendations for development and strengthening of quality standards included attention to wait list times, people orientation at arrival, staff knowledge and facility accessibility for physical disabilities, program and conceptual flexibility, carer and family participation, and transition to home checklist process.

Conclusion

Taken together, the findings in this report provide both encouragement for the visibility and value of practices implemented at the JMHSS service, and clear directions for how service quality can be strengthened in this setting. The results also highlight the potential to achieve remarkable levels of insight and innovation when service users and service providers come together to co-design service quality improvements.

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Appendix A

Diagram illustrating key components of JMHSS research study and linkage to quality improvement working group areas of inquiry.

Research Study Activities

1
Independent analysis of data from K10, GSES & WSAS measures

2
Analysis of hospital use data - pre and post JMHSS

3
Quality review

4
Economic analysis

Quality Improvement Activities

A
Making the important measurable: recovery & wellbeing

B
How does the JMHSS fill a systems gap?

C
What are the essential quality standards for JMHSS?

D
How does it all come together?

Knowledge/Understanding of:

Systems Impact: Value of JMHSS within local service system.
Service User impact: Value of JMHSS to peoples recovery outcomes.

Appendix B

Reflection:
The co-design process
by Dianne Zanetti

The working groups

I was a member of both working groups: the consumer focus group, which we called the Recovery and Wellness, or RAW group, and the Steering group which included myself and another consumer as well as Neami staff members.

Each group met separately, with the RAW group meeting first and the Steering group meeting a fortnight later. Prior to each meeting, the relevant data and research material was emailed with a Meeting Agenda that outlined the discussion areas. Participants spent a couple of hours reading through the documents and preparing pre-meeting notes.

The meetings began with the establishment and/or reinforcement of the group's rules, the distribution of printed material and confirmation all group members were familiar with the literature and prepared for the ensuing discussion. Research Co-ordinator, Keren Wolstencroft, chaired the meetings via Skype and for the most part, Margaret Kitto fulfilled the role of group facilitator.

During the meetings, discussions were stimulated by a group activity, or by the opinions expressed by group members. Each person would, in turn, put forward their ideas, give feedback and expand on points raised by others before any group consensus was formed.

The meetings closed with the practical activity of completing timesheets and the offer of one-on-one de-briefing should any group member need it.

After each meeting, participants spent a couple of hours reflecting on the points made and the discussion that followed before writing a summary of what they perceived as the important points and outcomes of the meeting. This post-meeting report was forwarded to Keren for inclusion in her qualitative data.

Collaboration

In the first meeting of each group, an activity was undertaken to determine what participants considered as recovery and wellness indicators. Group members were asked to write anything they thought of as an indicator of recovery and/or wellness on a sticky note. The sticky notes were placed on the wall and grouped into themed categories.

The RAW group results were not shared or discussed with members of the Steering group until after the Steering group had completed the same exercise. RAW group participants then gave feedback to the Steering group on the similarities and differences between the RAW and Steering group results. After the activity results were discussed, it was decided to list the indicators as internal and external signs of recovery and wellness.

A summary of the Steering group discussions was shared in the next RAW group meeting. Any additional feedback from RAW group members was passed on to the Steering group for further comment.

It was through the process of sharing, reflecting, revising and sharing again, that the groups collaborated to establish the consensus outcomes in the reported findings. Appendix A is what the two working groups agreed were the key indicators of recovery and wellness.

Discussions

During the recovery and wellness indicators activity, both working groups included 'physical health' as a category and listed key wellness indicators as things like regular exercise, good nutrition and sleep hygiene. Although both groups expressed a holistic attitude to recovery and wellness, the Steering group favoured observable behaviours including 'socialisation' and 'community engagement', while the consumer group included invisible factors like 'financial', 'residential' and 'emotional' stability on their list.

From compiling the recovery and wellness indicator's list (presented on page 7 of this report) and discussing the pros and cons of the tools currently used to measure recovery, we all learnt a great deal about how the other half thinks. Staff members discovered there were questions they didn't routinely ask consumers which could give them greater insight into the consumer's world. And, consumers realised they didn't always share enough information with staff to enable them to adopt a holistic or big picture approach.

Personally, I was surprised that social interaction and community engagement were viewed as key wellness indicators by both Neami staff and some consumers. I'd always thought an individual's level of socialisation was an indicator of personality rather than wellness.

I'd been frustrated when mental health professionals pressured me to attend regular group activities, to socialise with other mental health consumers and to do voluntary work outside my home. Now that I understand where they are coming from, I know I need to disclose more personal information to ensure the self-isolating behaviours I consciously adopt to protect myself during PTSD episodes are not mistaken for lifestyle habits that need addressing for me to become well.

The elements of co-design

Before the working groups could make any recommendations, we looked at the JMHSS from several angles. This was achieved firstly by determining the wellness indicators and then by comparing them to the tools used to assess and measure recovery. Next we undertook a quantitative (statistical) data analysis and a qualitative comparison between JMHSS, Hospital and Emergency Department admissions.

The next phase of the co-design process involved examining and discussing the national quality standards all Australian mental health facilities are meant to achieve and the international guidelines these standards were drawn from. These were also compared to the quality standards set for Western Australian mental health facilities and with the quality standards Neami expects the JMHSS to achieve.

In the final co-design phase, we discussed what we individually and collectively saw as the JMHSS strengths and weaknesses. We all contributed ideas and made suggestions as to how the JMHSS could maintain its strengths and introduce changes to address the areas identified as requiring improvement.

Concerns and benefits of co-design

I don't often engage in group activities, so I had concerns going into the research project. I thought I'd miss group-related social cues and suspected I wouldn't notice if I was dominating a discussion on something I felt passionate about, or that I wouldn't realise when people weren't interested in what I was saying. However, the main concerns I had about participating in the consumer group were that:

- the process would have a negative effect on my mental health
- I wouldn't cope with the workload involved
- I'd let people down if I couldn't attend every meeting
- content we discussed or wrote about could trigger my PTSD, and
- I'd unintentionally upset someone else.

Most of my concerns were addressed by establishing group rules which we all did our best to stick to. I did say things other people weren't happy with, but I wasn't the only one and when an issue we hadn't anticipated surfaced, we discussed a solution and added a new protocol to the group rules. This made it feel like a safe environment to open up and be honest in.

My primary motivation for wanting to be involved in the JMHSS evaluation was an altruistic belief that others would benefit from the wisdom and knowledge I had to share; however, as a writer, I'd anticipated secondary benefits both professionally, via the research experience and co-authored reports, and economically, through the reimbursement of our costs—including travel expenses and participation time.

I did gain the professional insight and work experience I'd expected, the compensation was generous and although I felt a sense of achievement from my personal input, I also found the contributions of other group members informative and inspirational.

Reporting the results

Keren Wolstencroft, has the mammoth task of collating the research data and deciding what is to be included and excluded from the final report. A second draft of the proposed report is currently under revision and the booklet produced by Keren for the overview presentation to JMHSS staff summarises information which will be expanded on in the published final report.

When I contemplated what could "possibly" be missing from the report, a few things sprang to mind.

Firstly, how quickly JMHSS acted to implement the recommendations we've made and how well the changes seem to be working; and secondly, how much more I got out of the co-design experience than I'd expected.

My unexpected findings

Most adults are treated respectfully and as equals by other adults within the community; however, if you are diagnosed with a permanent mental health condition, many adults, including mental health professionals, assume your intellect is also impaired and act as if they are superior to you. This is can be communicated non-verbally by ignoring what you say, by rolled eyes or raised eyebrows after you've spoken, or by using other equally dismissive actions that imply what you've said isn't important. This is a form of social rejection which, if repeated over many years, can be internalised as a belief that nothing you say is worth listening to, or that you as a person are not worth another person's attention.

Acceptance into the JMHSS evaluation project and as a working group member sub-consciously gave me "permission to speak". And, it wasn't until I started talking without holding things back that I realised how often I censored myself, or stayed silent, when I had something important to say. Being actively listened to and having my thoughts and opinions validated during the co-design process had a profound impact on my social-confidence, my self-esteem and to the value I place on using my voice and speaking my mind.

I still prefer solo, creative pursuits to group activities, entertaining at home to socialising in unfamiliar surroundings and deep, meaningful one-on-one conversations to small talk. I also still prefer to work from home than out in the community; however, finding my voice and having the opportunity to practice using it, has had some surprising results. My most recent work capacity assessment noted significant improvements in my social skills. This has inadvertently enhanced my employability and increased my future earning potential.

Future direction

As we move toward a more person-centred approach in medical and mental health care, health records written by an observer and from a medical perspective will need to be supplemented to include historical relationship, workplace, social, economic and residential issues that have impacted on the consumer's wellbeing.

Ideally, I'd like to see consumers given the opportunity to write a health-history narrative in an outpatient setting. This written document could provide the consumer perspective of past treatments and medications as well as give health professionals and support workers insight into the consumers growth so they can provide more continuity in their care.

As a mature-aged person with some counselling qualifications and years of therapy under their belt, I know how frustrating it is to present during a crisis and to be asked about my childhood, my position in the family and for historical information that has no bearing on my reason for seeking help. It would take six months in therapy to summarise my trauma history and if I've experienced a fresh trauma (such as when I received disabling physical injuries during a home invasion) that's what I want to talk about—not what happened in my childhood.

A written health and/or mental health narrative could serve the dual purpose of providing the consumer perspective on past medical and psychological treatments as well as having therapeutic benefits for the consumer. It could be used as a pre-admission document and forwarded to health professionals and support workers so they can work with the consumer by picking up from where they last left off instead of wanting to start at the beginning again.

If the proposed health narrative was updated to include subsequent physical or mental health treatment as part of the discharge process, the health narrative could help consumers to recognise their gains and assist with their transition from a mental health facility to home.

I have recently applied for a place in post-graduate studies to explore whether establishing writing therapy groups in the community could be a cost effective way to fill what the JMHSS working groups identified as a mental health system gap in outpatient services.

In my future, I see myself facilitating therapeutic writing groups and assisting consumers to write a life-history health narrative and I have my participation in the Neami research project to thank for pointing me in this direction.

Appendix C

Measures used in research study and examined by QI working group members

Name:______________________

Date completed:____/____/_____ ☐ **Entry** ☐ **Exit** *(Tick one)*

General Self-Efficacy Scale

Using the scale below, circle the number that best describes how true the statement has been for you **DURING THE PAST WEEK**.	**Not at all true**	**Hardly true**	**Moderately true**	**Exactly true**
1. I can always manage to solve difficult problems if I try hard enough.	1	2	3	4
2. If someone opposes me, I can find the means and ways to get what I want.	1	2	3	4
3. It is easy for me to stick to my aims and accomplish my goals.	1	2	3	4
4. I am confident that I could deal efficiently with unexpected events.	1	2	3	4
5. Thanks to my resourcefulness, I know how to handle unforseen situations.	1	2	3	4
6. I can solve most problems if I invest the necessary effort.	1	2	3	4
7. I can remain calm when facing difficulties because I can rely on my coping abilities.	1	2	3	4
8. When I am confronted with a problem, I can usually find several solutions.	1	2	3	4
9. If I am in trouble, I can usually think of a solution.	1	2	3	4
10. I can usually handle whatever comes my way.	1	2	3	4

Work and Social Adjustment Scale

Rate each of the following questions on a 0 to 8 scale: **0** indicates **no impairment at all**, and **8** indicates **severe impairment**.

1. Because of my health problem/s my ability to work is impaired.	0	1	2	3	4	5	6	7	8
2. Because of my health problem/s my home management (cleaning, shopping, cooking, looking after home or children, and paying bills) is impaired.	0	1	2	3	4	5	6	7	8
3. Because of my health problem/s my social leisure activities (with other people, such as parties, outings, dating, and home entertainment) is impaired.	0	1	2	3	4	5	6	7	8
4. Because of my health problem/s my private leisure activities (done alone, such as reading, gardening, collecting, sewing, and walking) is impaired.	0	1	2	3	4	5	6	7	8
5. Because of my health problem/s my ability to form and maintain close relationships with others, including those I live with, is impaired.	0	1	2	3	4	5	6	7	8

Name:________________________

Date completed: ____/____/_____ ☐ **Entry** ☐ **Exit** *(Tick one)*

K10 L3D – Self Report Measure

The following ten questions ask about how you have been feeling in the **last three days**. For each question, mark the circle under the option that best describes the amount of time you felt that way.

	None of the time **(1)**	A little of the time **(2)**	Some of the time **(3)**	Most of the time **(4)**	All of the time **(5)**
1. In the last three days, about how often did you feel tired out for no good reason?					
2. In the last three days, about how often did you feel nervous?					
3. In the last three days, about how often did you feel so nervous that nothing could calm you down?					
4. In the last three days, about how often did you feel hopeless?					
5. In the last three days, about how often did you feel restless or fidgety?					
6. In the last three days, about how often did you feel so restless you could not sit still?					
7. In the last three days, about how often did you feel depressed?					
8. In the last three days, about how often did you feel that everything was an effort?					
9. In the last three days, about how often did you feel so sad that nothing could cheer you up?					
10. In the last three days, about how often did you feel worthless?					

Total score __________

Thank you for completing this questionnaire.

Please return it to the staff member who asked you to complete it.

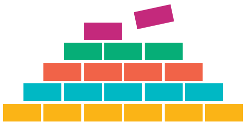
Appendix D

Some suggestions for converting an existing ground floor room into a more disability friendly room include:

- A steam mop or mop bucket that squeezes the water for you
- Long handled dustpan and brush
- Bed rail (as supplied)
- Grab rails for toilet and shower
- Remove the shower screen door and extend shower base by using a shower curtain rail
- Provide a slip mat for toilet/wet area
- Hanging hooks within reach of shower for town/robe
- Hooks behind bathroom door for robe/rain jacket
- Remove doors from vanity (for seated access)
- Relocate current face washer/hand towel rail to lower on the left
- Install bathroom cabinet on wall for toiletries etc.
- Replace current shower head with hand-held shower head and install hooks so it can be used at various heights (e.g. for washing hair in the seated position
- Install a shower bench seat and/or provide a shower stool (space to confined for a chair)
- Install an internal clothes line to hang over the laundry trough
- Kitchen stool

More information

The underpinning research



Step-Up Step-Down services provide residential accommodation supported by 24 hour staffing that frequently includes both clinical staff and recovery-focused non-clinical supports. Maximum lengths of stay vary in this model of care but are typically around one month.

Western Australia's first step-up, step-down mental health service opened in Joondalup in 2013 with 22 beds. In 2017, Neami researchers partnered with University of Western Australia Research Fellow Dr Hanh Ngo to undertake an evaluation of the Joondalup Mental Health Step-Up Step-Down (JMHSS) service. Dr Ngo has undertaken an independent analysis of data obtained from consumers during the course of their stay at the Joondalup Mental Health Step-up step-down Service (JMHSS) and data obtained from the Western Australian Data Linkage Branch.

Findings from the study indicate that people accessing Neami Joondalup service reported significant reductions in psychological distress, and significantly increased general self-efficacy as well as work and social adjustment, at service exit compared to service entry. Service users reported a high level of satisfaction with their stay at Neami overall, with at least 75% of the respondents to an Exit Questionnaire providing a rating of "Satisfied" or "Very Satisfied".

Results also showed that people who accessed the service benefited from reduced hospitalization rate (or number) and risk, shorter hospital length of stay, as well as reduced risk of presenting to hospital emergency departments.

For more information, or to request a copy of the report, contact us at:

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The Collaborative Recovery Model

The service practice Model at JMHSS

The Collaborative Recovery Model (CRM) was developed over a number of years at the The University of Wollongong and incorporates evidence of practices that have previously assisted people living with enduring mental illness.

The model is consistent with the values of the recovery movement and meets the criteria for a Recovery-Oriented Practice approach outlined in various Australian government Frameworks for Recovery-Oriented Practice.

The application of the model varies from site to site depending on the nature of the work taking place, however, all Neami National's services are expected to deliver services consistent with the Guiding Principles and the Key Components.

Peer Support Workers include the intentional and purposeful use of their own lived-experience to further an understanding of the recovery process.

Recovery is an Individual Process

Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness.

Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Collaboration and Autonomy Support

Research consistently shows there is a correlation between the strength of the working relationship between a person who is recovering and people who are assisting this process and mental health outcomes (e.g. Martin, et al., 2000).

The Collaborative Recovery Model uses a coaching framework to guide all interactions between consumers and service providers, emphasising and supporting self determination and efficacy as well as calibrating relational dynamics in a power neutral stance.

These guiding principles provide the foundations for the Collaborative Recovery Model and are used in all interactions in providing recovery support.

The Optimal Health Program

The Optimal Health Program (OHP) is a Recovery-Oriented Practice based program.

OHP is a self-efficacy building program that supports people to engage in wellbeing planning. It is aimed at supporting participants to achieve their optimal health in keeping with the key principles of personal recovery and that optimal health is self-defined and self-directed.

OHP considers the balance of social, emotional, mental, physical, occupational and spiritual needs. It provides tools to help identify priorities and then work towards progress in chosen area.

Benefits of the program

The Optimal Health Program is the result of research to develop a self-management program promoting hope, growth and partnership.

Previous participants have reported benefits including:

- Prevention of acute illness and relapse
- Less time spent in hospital and acute health services
- Greater confidence in managing your wellbeing
- Improved use of collaborative partners and supports.

The Optimal Health Program is a licenced, evidence-based, Collaborative Therapy program subject to copyright and owned by Prof. David Castle, Chair of Psychiatry, St Vincent's Hospital Melbourne.

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Improving Mental Health
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