An investigation into innovative, community based, psychosocial rehabilitation programs for young people experiencing mental illness.

New Zealand, Canada, USA, Sweden, Norway

Report by Janet Leslie - Churchill Fellow 2001
# INDEX

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index</td>
<td>1</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>2</td>
</tr>
<tr>
<td>Personal Reflection</td>
<td>3</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>Research Programme</td>
<td>5</td>
</tr>
<tr>
<td>Conclusions</td>
<td>12</td>
</tr>
<tr>
<td>Recommendations</td>
<td>13</td>
</tr>
<tr>
<td>Appendix A.</td>
<td>14</td>
</tr>
<tr>
<td>Principles of Psychosocial Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Appendix B.</td>
<td>15</td>
</tr>
<tr>
<td>Table and brief description of 36 programmes</td>
<td></td>
</tr>
<tr>
<td>visited for research.</td>
<td></td>
</tr>
</tbody>
</table>
Acknowledgments

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Thanks to the individuals from local Melbourne PDSS services who gave input into the research prior to leaving. Thanks to friends and family for the inspirational emails, letters and packages whilst on the road.

Thankyou to Ken Jones at Tech-Rentals and his generous loan of a notebook computer for the research.

Thanks to Peter Enlund of Box Hill Central Rotary club for helpful connections, particularly those with Stavanger Rotary Club.

A special thanks goes to Asenati Toilolo, Kevin Leslie and Rick Graham, Tony Zipple and Cathy Boucha, John Erik and Wenche Olstad who all overwhelmed me with their hospitality, welcoming me into their homes, lives and their intimate knowledge of local culture.

I am particularly thankful to the programs I visited, their hospitality and openness was invaluable for this research. I am so grateful for the willingness of managers, staff and participants to show me the work that they are so proud of, the countless photocopies, the gifts of books and articles, the tours of the cities, peoples homes, the lunches and breakfasts and time given to discuss the ins and outs of their rich experiences.

Finally, my gratitude to the Churchill Fellowship for their interest in the needs of young people experiencing mental illness, their faith in me to collect information about this area, the excellent support in the practical bits and the endless positive encouragement. I am very proud to be a Churchill Fellow and look forward to future involvement with this Association.

JANET LESLIE     Dip Ed(Prim), Grad Dip Adol Hlth
Churchill Fellow 2001
Personal Reflection.

This research project has been a fine experience, with some expected and also unexpected outcomes along the way. Here are some reflections of my Churchill Fellowship experience. Perhaps this will be useful for future Fellows in their endeavours.

My first discovery was that it is almost impossible to look at programs in isolation without first having some understanding of the systemic structure the funding, service provision configuration, bureaucratic, political and cultural issues. This may seem a huge task, but an important one to have. A basic contextual understanding is invaluable. Much time was spent trying to work out the Victorian counterpart to the configuration of services in the country visited.

Secondly, starting with a very defined topic that I believed, was very specific, should have meant that the programs visited would have all fallen very neatly into the research – but that was a very naive expectation. An analogy of the process may be as follows - expecting to look at dairy cattle, but getting a tour of the whole farm yard –chickens, sheep, machinery and all! For example, the term ‘community based’ in Victorian psychiatric disability support services usually means non-government, non-clinical programs that are usually situated in the communities that they serve. The term ‘community based’ in Norway and Sweden was interpreted to be services provided by the ‘Kommune’, which is a regional government system that manages all health and community services such as hospitals, health centres, schools and other public services. Therefore, some of the programs that I visited, although very informative and interesting, were not strictly within the research topic.

Finally, it was not an uncommon experience to arrive at the host service and be provided with a list of people and services that would be of interest to make contact with. Often time did not allow this, thus leaving a ‘just scratching the surface’ feeling when it was time to leave each country.

I am thankful for this experience and I am very grateful to the Winston Churchill Memorial Trust for giving me the opportunity to carry out the research.
Executive Summary

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This report details the information gathered by Janet Leslie, Year 2001 Churchill fellow, during her travels through New Zealand, Canada, USA, Sweden and Norway. Janet undertook research into innovative community based psychosocial rehabilitation programs for young people who have experienced mental illness.

The state of Victoria devotes 14% of its annual mental health budget to community based Psychiatric Disability Support Services (PDSS). These services include day programs, residential rehabilitation programs, mutual support and self-help groups, respite services and home based outreach and support programs. PDSS programs aim to provide support and rehabilitation programs for people who have experienced the debilitating and often, catastrophic consequences of mental illness. PDSS programs base their practice on the Principals of Psychosocial Rehabilitation. (see Appendix A)

There has been awareness for some time in the Victorian PDSS sector that the needs of young people are not necessarily met by current service structures. The sector serves people within 16-65yrs - an enormous age range. Although some programs are exclusively for young people, for example, youth residential rehabilitation programs, many programs are greatly challenged to address the specific needs of young people within the context of current funding levels. There is strong argument that to improve access, participation and outcomes for young people with mental health issues, stand-alone programs are needed. The provision of youth specific programs is often at the cost of other essential areas of the service, for example, drop-in hours in a day program.

A program that effectively serves young people will take into consideration the developmental needs of the target group. Theorists suggest that there are a number of developmental tasks individuals must address for successful development. These tasks may include working towards independence, the development of self-concept, future life directions, the effective use of support networks including peer networks and the development of effective relationships.

Janet’s research set out to investigate how other countries address the needs of young people, in particular, programs that display responsive, relevant and recovery focused services.

Services highlighted in this report include:

1. Challenge Trust – Auckland, New Zealand
   Consumer Consultant employment at all levels of the organisational system.
2. Mental Patients Association (MPA) – Vancouver, Canada
   Client centred practice.
3. Vinfen – Young Adults Program - Boston, MA. USA
   Innovative young adults day program
4. Vinfen – Crisis Stabilisation Adolescent Unit– Boston , MA. USA
   Crisis respite and treatment service for young people experiencing acute mental health problems.
5. Maria Youth Clinic – Stockholm, Sweden
   24hr drug and alcohol rehabilitation service
6. TIPS Early Intervention Program – Stavanger, Norway
   Multi family support and education groups.

This research has found both innovative and essential factors in the provision of effective services for this target group. Programs need to be culturally sensitive, developmentally appropriate, consumer focused, use the young persons networks effectively and be provided in a timely manner along side early intervention from clinical mental health services. There is also a need for close partnerships between the PDSS sector, mental health clinical services and other generalist services such as housing, education and employment. These issues are detailed in the later sections of this report.
Research Program

In total, Janet visited 38 programs of which 6 are highlighted in this report. (See Appendix B for details of the other 32 programs.) Some of the programs showcased may fit better in the clinical or the drug and alcohol sector, rather than PDSS. The programs showcased in this report were chosen because they displayed a combination, or all of the following traits that display innovation and best practice of rehabilitation programs to value, by providing responsive, reflective and relevant services to young people who have a mental illness.

The traits contain many aspects of the principles of psychosocial rehabilitation (PSR – see appendix A), and are as follows.

Recovery focused services

A good definition of the concept of recovery is from Cheryl Gagne’s keynote speech ‘Recovery: the journey of hope”, at the 1996 Vicserv State Conference. Gagne stated that recovery refers to a process of growth – rather than a destination or end point. The emerging concept of recovery is described as a deeply personal, unique process of change, of changing one’s attitudes, beliefs, values and goals. It is a way of living a satisfying and hopeful life despite the limitations caused by the illness as well as by stigma. It involves the struggle of new purpose and meaning as one grows beyond the catastrophe of mental illness.

Early intervention

Research shows that it is essential that quick (crisis) intervention is given when the first warning signs of onset of a psychotic episode, decompensation or dysfunctioning are observed. This can reduce re-admissions to hospital and preserves most acquired skills and community ties including job, housing and social contacts.

Cultural sensitivity

It is important when working with the young people to acknowledge the culture or sub culture a young person identifies with. This may include ethnic, language, religious or sub cultures such as street culture.

Developmentally appropriate.

Insight into the theories of adolescent development is essential. It is suggested by theorists that there are a number of developmental tasks individuals must address for successful development to adulthood and independence.
Consumer focused and self-determination.

Individuals have the right and the ability to participate in making decisions regarding their lives and to do so on a regular basis. Programs must have partnership with service users to inform relevant, dynamic best practice in service delivery. Participants are encouraged to take an active role in planning, policy development, delivery and evaluation of services.

Effective use of networks

The effective use of networks has two areas of focus. Firstly, PDS services must be effectively linked in with other departments of the service system so as to provide seamless service provision and minimise the 'red tape' factor. This includes organisations such as the Office of Housing, Centrelink, community based generic programs, clinical mental health services, neighbourhood houses, educational and employment programs. Secondly, to assist in enabling an individual to maintain independence, a sturdy support network consisting of peers, friends and/or family and other social/ community structures such as sporting clubs or support groups is essential.

Normalisation.

Each individual has the right and is expected to live and function in the setting that is least restrictive and that as closely as possible approximates a regular community setting.

The following programs visited stood out as having innovative and best practice in service provision. I have highlighted components of programs or service philosophy that stand out as exceptional, though these programs are more complex and multifaceted than described in this document.

**Auckland - New Zealand**

**Challenge Trust**
Program Manager - Lorna Murray
P.O. Box 23647
Hunters Corner, Auckland
Ph: 277 7595

**In Service Consumer Consultants**
Challenge Trust provides outreach support for 125 people in their own homes, and residential rehabilitation services in five locations throughout the South Auckland region. Challenge Trust works with people with complex needs, including those with dual diagnosis and forensic issues. Although acknowledged as an important group that have special needs, young people do not make up a large proportion of participants in the service. Challenge Trust has a commitment to working with families and has client centred practice. Challenge Trust also runs community groups on dual diagnosis education and information and support groups for families.
Challenge Trust began in 1996, and from its inception factored into its structure the employment of consumer consultants they call client representatives. Consumer consultants are people who have had a personal experience of mental illness, used the psychiatric services system, and use their experience as an expertise base in a professional capacity. They are often asked to volunteer or are employed by mental health services to assist in informing user sensitive and best practice in service delivery. This is also common practice in Victoria, as in New Zealand.

At Challenge Trust, nominated participants of programs are employed as consumer consultants so that there is a culture of partnership between the providers and participants for service delivery and direction. Peers and staff do the nominating process.

A Senior Client Representative is employed for 20 hours per week and has direct access to the Chief Executive Officer. Each program (5 residential rehabilitation programs and the outreach support program) elects a service representative and deputy representative. They are employed for up to four hours per week. All positions are paid $10 per hour. There is an attempt to have a broad representation of participants as Client Representatives such as age, gender, ethnic and cultural representation.

The Senior Client Representative’s tasks include facilitating a monthly Service Representative Meeting, providing training for Program Service Representatives, bringing guest speakers for client meetings and attending management meetings. The Senior Client Representative also brings together consumers writings and current Challenge Trust news in a regular newsletter called ‘Inspirations’. Client Representative duties include collecting feedback and suggestions from their services, and bringing that to fortnightly staff meetings for discussion.

As with most services I visited in New Zealand, a Maori Representative, a member of staff, was employed to oversee service protocols in relation to cultural safety. Part of this worker’s role was to spend some time in direct service delivery with Maori participants in assisting them to embrace or connect them to Maori culture. Another role that the Maori Representative performed was to ensure and encourage cultural safety was embraced within Challenge Trust.

I was most impressed with Challenge Trusts intrinsic culture of consumer informed practice and service delivery. Paying client representatives for consumer consultation did not detract from service participation and volunteerism from non-paid service users. Paying client representatives does empower participants, by the acknowledgement of expertise by remuneration, and ‘voice equality’ about service provision with non-consumer staff and management. Challenge Trust’s organisational structure is a fine example of consumer and culturally sensitive practice.
Vancouver - Canada

Mental Patients Association (MPA) –
Laurie Koziak – Housing Manager
#202 – 1675 West 4th Ave
Vancouver, BC. V6J1L8
Canada
Ph: (604) 738-2811

Youth Supported Independent Living (YSIL)
Home Based Outreach Program

Youth Supported Independent Living (YSIL) program is one of a range of psychiatric disability support services provided by Mental Patients Association (MPA). MPA provide day programs, drop-in centres, adult supported living programs, outreach services to rooming houses, peer support programs and consumer rights and legal advice services. MPA’s philosophy is centred around the rights of the individual to appropriate and timely medical care and access to community resources for people with a mental illness. The organisation is nearly 30 years old and started with a group of consumers and carers getting together to improve conditions for ‘mental patients’.

MPA embraces consumer-centered practice, in which services are provided for people, rather than people fitting into services. This is reflected in the YSIL model. YSIL provide support to ten young adults with two full time support workers. This program relies on strong partnerships between the department of housing, human services, mental health clinical services and the private rental providers to bring optimal outcomes. The goal is to have the process of moving into independent living as seamless as possible for the young person.

Many of the young people, aged 16-20 years, have been referred from protective services or child and adolescent clinical services. The YSIL program focuses on bringing the supports and resources to the client, rather than requiring the young person to do the run around. The young person can then focus on life skills development, rather than the stress caused by negotiating bureaucratic systems. The office of housing gives a subsidy of $700 per month toward renting a property on the private rental market. This means that the young person is able to choose the area they live in so that they are close to their support network. There are ideological arguments against government programs financially supporting private rental market investors as a waste of taxpayers dollars – the argument being money should be put into public housing. Public Housing is very limited in Vancouver, and MPA staff explained that this was a viable set up for this target group in that it encouraged the young adults to live in a situation similar to their peers, rather than the ‘institutionalised’ rigidity of public housing from a young age.
In British Columbia a person is not able to legally sign a lease if they are under the age of 18 years. The support worker assists the young person in securing the rental property and MPA takes on the legal requirements of signing the lease and then sublets it to the young person. When the young person has lived there for a number of years and has shown that they are able to manage the tenants’ obligations, the lease is signed over to them.

The support worker fulfills a role very similar to those of a home-based outreach support worker in our state of Victoria. In partnership with the young person, goals are set that work towards recovery and independence. MPA attempts to focus on providing extra support in the areas of social skills, vocational and educational issues and family linkages where appropriate.

The strength of this program is in the strong links between government departments of housing, PDSS, child protection services and the Vancouver equivalent to Centrelink. Therefore, a young person accessing the YSIL has the minimum amount of red tape to encounter, improved access to housing options and support that helps to ensure a successful path to independence.

USA – Boston, MA

Vinfen Young Adults Program
Jennifer Lakins – Program Director
1050 Commonwealth Ave #200
Boston, MA02115
USA
Ph: 617 232 6120x317

Young Adults Housing & Day Program

The Vinfen Young Adults Program consists of two main components. Firstly, a residential rehabilitation program that has a number of group homes that are supported by outreach support workers. Secondly, one of the most innovative programs visited for this research project - the Young Adults Rehabilitation Day Program (YARD).

YARD successfully engages young adults (18-30yrs) who have experienced the disabling affects of mental illness and provides a safe environment with their peers who are facing the same life issues. The program has an emphasis on meaningful, action-oriented activity, developmentally in line with their individual rehabilitation goals. YARD aims to provide a forum that develops critical thinking as well as decision-making skills that will naturally extend into other areas of the young people’s lives. Participants enrol for semester/term periods.
The program has up to twelve young adults attending daily, and up to 18 YARD program graduates on maintenance support, which means that they have some access to the support workers and can attend social events, such as video nights. The YARD program takes place in an office suite that has other Vinfen programs running from it in inner urban Boston. Although the suite has a corporate type entrance, the physical environment in the YARD program is relaxed and similar to a youth resource centre. The program has two full time workers, with extra support from the Young Adults Housing Program staff who take some classes. The Young Adults Housing Program is based in the same building. YARD staff agree that it is very important for the program’s physical environment to be safe, comfortable, informal and age appropriate. The staff acknowledged the importance of a separate venue from the other adult day programs, and believe that this is one of the contributing factors to the success of the program. The entrance and building type is not optimal in its corporate format, but space in Boston is at a premium.

The program is structured in a manner similar to school, with classes/groups, lunch breaks in a term/semester format. The topics of classes include peer support, fitness, symptom management, life skills, further education, vocation development, community involvement and other health topics. The young adults are involved in designing the curriculum. They are also instrumental in planning the social/recreation aspect of the program, for example excursions or shared meals. The YARD program focuses on a curriculum that is developmentally appropriate, as it addresses the life issues of young adults. It also is formatted in a manner that is in line with what the participant’s peers are doing – that is going to ‘school’, attending pre-employment programs or further education, and thus minimises the stigma of participating in a psychiatric disability program. This is in keeping with the psychosocial rehabilitation principle of ‘Normalisation’. This principle states that each individual has the right and is expected to live and function in the setting that is least restrictive and that as closely as possible approximates a regular community setting.

This type of program would well suit the psychiatric disability support service system in our state of Victoria. Victorian PDS services that wish to run youth specific programs, must do it with the current funding resource base, which often means decreasing resources from other groups such as drop-in hours. It also usually means that due to staffing levels, the young people’s program often has to be run from the general service space and so it is difficult to have client ownership of the space. This can be a detractor for some young people who want the support of the service, but do not want to be associated with a ‘disability’ group.
Crisis Intervention and Respite Service

Although CSAU is a clinical service, it is included in this report because it is quite different from any service currently available in Victoria. The CSAU provides comprehensive, community based crisis intervention to young people experiencing episodes of acute mental illness. This service aims to enable young people to return to their families and communities in the shortest time possible. Most young people stay under a week in the program.

The focus of the treatment at the CSAU is to reduce acute symptoms through medication, groups and family work, to identify and stabilise factors that precipitated the episode, and reconnect the young person with outpatient services. This program successfully provides a safe ‘time out’ space for young people and their families in situations of crisis. This program does not serve those who are suffering from a psychotic episode, but is best used for supporting young people who may be in depression, have personality disorders, are suicidal, or have a situational crisis that is overwhelming for them. The CSAU has 11 beds and provides 24hr care, with a daily visit from a psychiatrist.

This model may be useful in the Victorian clinical mental health service system, as it is able to provide crisis care and respite for young people and their families. It is often very difficult for families to obtain inpatient care unless there is an acute medical or psychotic crisis. The respite and intensive solution focused interventions provided for young people in emotional or situational crisis has proven to be a valuable model for this target group.
Stockholm - Sweden

Maria Ungdom (Maria Youth Clinic)
Arne Nordberg –senior social worker
Friskvardsvagen 4
St Gorans sjukhus
Stockholm
Sweden

Drug and Alcohol Service

This service primarily is a drug and alcohol service for young people aged 13-20 years and their families. It is attached to one of Stockholm’s major hospitals and offers 24hr care and access to its services. It provides emergency admissions, inpatient detoxification services, family work, peer support groups and individual counseling. Maria Youth Clinic has close working relationships with school social workers, the police, community health centres and mental health clinical services. The Clinic has a focus on early intervention and prevention.

Although it is not a psychiatric disability support organisation, I have included it in this report because I believe that it is quite a unique model in early intervention work with young people who have drug/ alcohol issues and provides a holistic approach to working with families. It is not uncommon for young people in the early stages of onset of mental illness to attempt to minimise their symptoms through drug and alcohol use. It therefore follows that a drug and alcohol service that is affective in early intervention is also well placed to identify young people that may be showing the early warning signs of mental illness.

Maria Youth Clinic’s 24hr access is a real bonus in service delivery. The window of opportunity for collaborative work with young people in crisis is often quite small. It is invaluable to be able to provide the assistance within 24hrs of help being requested – an appointment made for two weeks later is often seen by the young person as irrelevant to the immediacy of their crisis. Young people and their families can admit themselves into the Clinic at any hour of the day – and are seen within a 24hr period by a doctor. A decision is then made as to whether the young person needs a short or long term detoxification program, family counseling, parents support group, peer group support, individual counselling or some other assistance, such as a referral to a mental health service.

There is a strong focus on working with the family system, with support provided to the individual and other family members. If the young person is over 18yrs they may use the service independently of their family.

The focus on early intervention, effective and timely treatment, ease of access and appropriate referral on to other resources such as clinical mental health services are all strong aspects of this model.
Stavanger - Norway

TIPS Project
Jan Erik Nilsen – Head Nurse
Rogaland Psykiatriske Sjukehus
Postboks 1163, Hillevag
N-4095 Stavanger
Norway
Ph: 51 51 51 51 (30)

Multi-family group work

The TIPS Project is the research component of Child and Adolescent Clinical Psychiatric Services in Rogaland County for people experiencing first onset psychosis.

TIPS uses a complex multi-pronged approach that consists of early detection of mental illness through an assertive public mental health campaign, quick response for diagnosis (1st appointment within 24hrs), low dose medication plans, psychotherapy for the young person and multi family group work.

The multi family group work is based on Prof. William MacFarlane’s model. Multi family group work as practiced in the TIPS project brings together groups of five families that have a member with a first episode of psychosis to meet on a fortnightly basis over a two-year period. The group is facilitated by trained members of the TIPS staff team, and follows a strict formula. The Multi Family Group forms a peer support group as well as provides a forum for education and support from specialist services. One of the criticisms of clinical care in Victoria is that families often complain of not having enough information or access to professional assistance as a family unit, and little involvement in the treatment plan and recovery of their child.

MacFarlane’s model may be an asset to the Victorian service system. This model could be successfully adopted by PDSS organisations in Victoria in partnership with clinical services if resources were made available. Currently in Victoria, groups such as ARAFEMI’s ‘Bridging the Gap’ carer support group are very successful in providing peer support. The MacFarlane model, or a small peer group could work well in conjunction with established self-help groups.
Conclusions

This research has found both innovative and essential factors in the provision of effective services for this target group. Programs need to be culturally sensitive, developmentally appropriate, consumer focused, use the young persons networks effectively and be provided in a timely manner along side early intervention from clinical mental health services. There is also a need for close partnerships between the PDSS sector, mental health clinical services and other generalist services such as housing, education and employment.

The programs show cased in this report were chosen because they displayed a combination or all of the following traits that display innovation and best practice of rehabilitation programs to value, by providing responsive, reflective and relevant services to young people who have a mental illness.

The traits contain many aspects of the principles of psychosocial rehabilitation (PSR – see appendix A), and are as follows.

1. Recovery focused services

2. Early intervention

3. Cultural sensitivity.

4. Developmentally appropriate.

5. Consumer focused.


7. Normalisation.

This report will be disseminated to Department of Human Services, Mental Health Branch, Vicserv and other PDSS organizations.

Janet has accepted invitations to present the search at a number of forums including Stavanger Rotary Club, ARAFEMI -Bridging the Gap Carer Support Group and the Vicserv Breakfast Forum which is attended by PDSS workers. Janet will continue to be actively involved in PDSS sector development for services to young people who have experienced mental illness and the effects of psychiatric disability.
Recommendations

1. That the Victorian Mental Health Branch, DHS, facilitate a PDSS youth services audit and Young People In PDSS Needs Audit and Analysis. This is to be done in consultation with consumers, parent/carer groups, PDSS services and the peak body – Vicserv.

2. That the Department of Human Services – Mental Health Branch provide the extra resources needed to carry out the recommendations from the Youth Needs Audit and Sector Forum.

3. That Vicserv facilitate an audit of needs and current service provision, things that are working and not working and make a submission to DHS on behalf of the sector.

4. That a pilot project be funded to put together a Document of Practice for Working with Young People in the PDSS sector be created for all services to use as a base for service delivery for this target group. This document may include issues such as developmental sensitive practice, young people’s needs and the principles of psychosocial rehabilitation, access and equity.

5. That DHS look to providing better structures within the clinical mental health and PDS service system that improve the support of carers and carer links with the rehabilitation and recovery process of young people. This may include funding for the facilitation of multi family support groups that have clinical and PDSS support.

6. That a pilot project Young People’s Day Program be set up to explore the value of such a service for regional use.

7. That further resources be provided from DHS to factor in the employment of consumer consultants within PDS Services as a way of acknowledging the valuable input that consumers put into improving service provision at all levels.

8. DHS explore the possibility of 24hr access crisis and treatment services with examples of the Maria Youth Clinic in Stockholm and CSAU in Boston investigated.
Appendix A.

The Principles of Psychosocial Rehabilitation (PSR)

Sourced from the Vicserv Induction Kit.

1. **Under utilization of full human capacity** – the assumption here is that each person is capable of improving his or her levels of functioning.

2. **Equipping people with skills** – it is the presence or absence of skills, not clinical symptoms, that is the determining factor in rehabilitation success.

3. **Self-determination** – individuals have the right and the ability to participate in making decisions regarding their lives and to do so on a regular basis.

4. **Normalisation** – each individual has the right and is expected to live and function in the setting that is least restrictive and that as closely as possible approximates a regular community setting.

5. **Differential needs and care** – people psychiatric disabilities have individual physical, emotional, social and intellectual needs, as well as different personal bases of knowledge, skills, experiences, and attitudes that all together form a unique set of preconditions. Growth from dependence to independence is a highly individual process.

6. **Commitment of Staff** – genuine concern with the well-being of clients and belief that they are capable of progress must be of paramount importance.

7. **Deprofessionalisation of service** – the human element in staff performance is a crucial part of the rehabilitation process and staff are expected not to shield themselves behind a professional front.

8. **Early intervention** – it is essential to PSR that quick (crisis) interventions given when first warning signs of decompensation are observed, this can reduce readmission and preserves most acquired skills and community ties, including job, housing and social contacts.

9. **Environmental approach** – the process of rehabilitating people with emotional disabilities cannot be restricted to internal changes, the immediate environment of each person should be structured to provide support i.e. their families and/or social network.

10. **Changing the environment** – consists of not only relatives, friends, employers and neighbours, but also of broader societal institution, such as medical services, policies of income support, housing, community services and public attitudes toward people with psychiatric disability. This refers to the need to restructure and reeducate the environment to better absorb and care for people with psychiatric disabilities.

11. **No limits of participation** – this maintains no limits on length of participation and imposes few selection criteria, usually anyone who has been in a psychiatric hospital or who is exhibiting symptoms of difficulties in functioning is accepted, with the exception of those few who need specialised programs.

12. **Work-centred process** – work must be a central theme in any rehabilitation process, underlying, pervading and informing all the activities of the organisation.

13. **Social rather than medical supremacy** – the medical model of caring for people with psychiatric disabilities stresses the work ‘illness’. PSR, on the other hand, stresses skill-building and social support systems to assist persons to be better equipped to deal with life’s stresses.

14. **Emphasis is on the client’s strengths rather than on pathologies.**

15. **Emphasis is on the here and now rather than on problems from the past.**
### Programs visited

**Auckland**  
**New Zealand**

<table>
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<th>Service Name</th>
<th>Contact Person</th>
<th>Service Type</th>
<th>Target Group</th>
<th>Other Comments</th>
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<tr>
<td>Te Ha O Te Oranga O Ngati Whatua – Mental Health/ Alcohol and Drug Services</td>
<td>Yvonne Boyd Service Co-ordinator</td>
<td>Housing and outreach support</td>
<td>17 years plus Maori people and their families and communities</td>
<td>Focus on a cultural context of individual within a community</td>
</tr>
<tr>
<td>AMHS Accommodation For Mental Health Society</td>
<td>Rob Warrener Employment services co-ordinator</td>
<td>Psychiatric disability employment Housing &amp; Outreach Support Residential Rehab</td>
<td>18-65yrs Regionally based</td>
<td>Over the past 5 years 16% of clients (100 people approx) are aged between 19-25yrs.</td>
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<tr>
<td>Challenge Trust</td>
<td>Lorna Murray Program manager</td>
<td>Residential Rehabilitation Community education</td>
<td>Focus on people who have a psych disability as well as forensic issues and dual disability.</td>
<td>Consumer focused. High number of consumer representatives including a Maori consumer rep. Active consumer forum</td>
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<tr>
<td>Challenge Trust</td>
<td>Wayne Dye – consumer consultant</td>
<td>Senior client representation</td>
<td>Oversees other consumer consultants in Challenge Trust</td>
<td>Highlighted service in report.</td>
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<tr>
<td>Organization</td>
<td>Name</td>
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<td>Target Population</td>
<td>Funding Details</td>
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<tr>
<td>Starship Adolescent Services St Lukes A+</td>
<td>Bev George - psychologist</td>
<td>Community based clinical child and adolescent services</td>
<td>0-18yrs</td>
<td>Work with young people for 2yrs+ Have a number of innovative programs working with families and people from CALD backgrounds</td>
</tr>
<tr>
<td>De-stig Project Public Health Group Ministry of Health</td>
<td>Warren Lindberg – National manager</td>
<td>National public health promotion campaign</td>
<td>All New Zealanders</td>
<td>Mass Media $10million over five years</td>
</tr>
<tr>
<td>Youth Line</td>
<td>John Winger</td>
<td>Peer facilitated personal development groups Action Education Group Help line phone service Public Education Networking group (PEN)</td>
<td>Any young person interested in participating in peer support and is committed to the training.</td>
<td></td>
</tr>
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<tr>
<td>Schizophrenia Fellowship</td>
<td>Nicole Chovil</td>
<td>Carer support service. Lobby group</td>
<td>Carers of people with a mental illness</td>
<td>Have a network of outreach support workers. Run peer support groups across B.C.</td>
</tr>
<tr>
<td>Crossroads Coast Foundation</td>
<td>Renay Baykey Program manager</td>
<td>Residential rehabilitation with limited outreach support follow-up</td>
<td>Young women 19yr to 30yrs</td>
<td>Works with people who have had a history of being difficult to house.</td>
</tr>
<tr>
<td>MPA Mental Patients Association Yth SIL team</td>
<td>Laurie Koziak Residential Program Manager</td>
<td>Supported accommodation program Intensive outreach model. Activity program.</td>
<td>16–21 yrs Linkages with adult SIL when service users pass this age.</td>
<td>Strong consumer directed focus Direct links to Ministry of Child Care (child protection)</td>
</tr>
<tr>
<td>Vancouver Community Health Services.</td>
<td>Shauna Chetna</td>
<td>Special outreach unit for street involved youth</td>
<td>Primarily does one to one counselling. Outreach at youth hangouts.</td>
<td>Works with people who suffer from depression, personality disorders, not so much psychosis.</td>
</tr>
<tr>
<td>Dual Diagnosis Program</td>
<td>Pohsuan Program manager</td>
<td>Support groups and Dual Disability Psycho-educational courses</td>
<td>Harm Reduction Model. Cycle of Change 3.5 staff service 300 clients per month.</td>
<td>Clean and sober on day of attendance. Model is not aimed or structured for young people</td>
</tr>
<tr>
<td>The Art Studios</td>
<td>Sheila Cambler</td>
<td>Art studio space, equipment and instruction</td>
<td>Encourages art as a vocation. Open to anyone with psychiatric disability</td>
<td>Consumer artists are often employed as instructors.</td>
</tr>
<tr>
<td>Eastside Rehabilitation Services</td>
<td>Deborah</td>
<td>Intensive outreach support service</td>
<td>Work with all age ranges but have one worker that targets 16-19yrs High CALD and dual disability population</td>
<td>Focus on people with high support needs. Life skills, ESL classes, recreation</td>
</tr>
<tr>
<td>First Nations Mental Health Program</td>
<td>Perry</td>
<td>Secondary consultation to other professionals. Advocacy service</td>
<td>Covers 9 mental health areas in BC. (single worker) 375 first nations people using adult mental health services</td>
<td>Advocacy for counselling, community education and housing. Works with First Nations holistic health model and the medical model.</td>
</tr>
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<tr>
<td>Training Unit Vinfen</td>
<td>Troy and Margaret Position</td>
<td>Staff education in service orientation, rehabilitation, OH&amp;S, medication administration, management</td>
<td>Staff that work in the 200 programs that Vinfen run</td>
<td>State of MA requires all staff have first aid, CPR and medication administration training.</td>
</tr>
<tr>
<td>Gateway Vinfen</td>
<td>Ted Program Coordinator</td>
<td>Visual Arts Studio</td>
<td>18-82 years</td>
<td>Art work in marketed and sold. Artists make 60% or the profit.</td>
</tr>
<tr>
<td>Webster House 1&amp;2 Vinfen</td>
<td>Veronica Program Coordinator</td>
<td>Clubhouse models</td>
<td>18-</td>
<td></td>
</tr>
<tr>
<td>Young Adults Housing Program Vinfen</td>
<td>Jon Murphy Tracey</td>
<td>Group Home Model Outreach support</td>
<td>18-</td>
<td>Staff from housing program assist the day program by running groups.</td>
</tr>
<tr>
<td>Young Adults Day Program</td>
<td>Sarah Dyer Program Coordinator</td>
<td>Day program</td>
<td>18-30yrs</td>
<td>Focus on socialization, community access, living skills and health and wellness.</td>
</tr>
<tr>
<td>CSAV</td>
<td>Karen</td>
<td>Crisis intervention respite service</td>
<td>12-18</td>
<td>Assess and treat young people who may be suicidal, depressed or are at risk of harm.</td>
</tr>
<tr>
<td>Community Rehabilitation Service</td>
<td>Sirouss Mobed Program Coordinator</td>
<td>Outreach support service</td>
<td>20-70yrs</td>
<td>Work closely with clinical services</td>
</tr>
</tbody>
</table>
## Stockholm
### Sweden

<table>
<thead>
<tr>
<th>Service Name</th>
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</thead>
<tbody>
<tr>
<td>Homeless Outreach Team</td>
<td>Anna Lisa Suvanto</td>
<td>Mobile outreach health service</td>
<td>Homeless and street involved people</td>
<td>Provides treatment and community linkages for a range of physical and mental health needs. Holistic approach</td>
</tr>
<tr>
<td>Maria Youth Clinic</td>
<td>Arne Nordberg</td>
<td>Drug and Alcohol detox and rehab service</td>
<td>13-20years</td>
<td>Work in partnership with mental health services. Medical model. Focus on families Admission 24hrs a day, 365 days a year</td>
</tr>
<tr>
<td>Activity Centre</td>
<td>Kenneth Nykvist</td>
<td>Psychiatric Disability ‘TAFE’</td>
<td>18-65 years</td>
<td>A range of courses in textiles, languages, music, furniture restoration etc are provided. Study skills and work preparation is also offered.</td>
</tr>
<tr>
<td>Midgard St Gorans sjukhus Polemsgatan</td>
<td>Ulla – a resident of the program</td>
<td>Residential Rehabilitation – long term supported housing with some limited outreach support</td>
<td>Adults – people between 41-55 years at time of visit living in program. Some young people on outreach</td>
<td>Morning meeting at 8.30 am each day. One day a week residents have lunch together.</td>
</tr>
<tr>
<td>Ungdomsjouren</td>
<td>Katarina Regius</td>
<td>Provide emergency links between the police and social services for young offenders. In both detention centres and street outreach work.</td>
<td>17-20yrs Young people with legal issues</td>
<td>Good links with Maria Youth Clinic and mental health services.</td>
</tr>
<tr>
<td>Parachute Programme Midgard St Goran sjukhus</td>
<td>Dr Neil Cleland – psychiatrist Yvonne Arctaedius – head nurse</td>
<td>Early intervention and prevention program.</td>
<td>Young people with a first episode of psychosis and young people at risk of psychosis</td>
<td>Close links with TIPS in Norway and Eppic in Melbourne</td>
</tr>
<tr>
<td>Polhem</td>
<td>Tom Elliot Senior nurse</td>
<td>Clinical outreach service</td>
<td>18–65yrs. Focus on people with complex needs such as dual disabilities, eating disorders, BPD.</td>
<td>Similar to MSTS in Victoria.</td>
</tr>
</tbody>
</table>
### Service Name | Contact Person | Service Type | Target Group | Other Comments
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**TIPS Intake team** | Margreta TyHandrik Ase Suland | Intake for TIPS research project. Do further testing at regular intervals – 3month, 1,2,5 year period | Any person experiencing a first episode of psychosis. Youngest person is 14 years, oldest is 65yrs. | Voluntary participation.

**Rogaland Psychiatric Hospital** | Prof. Jan Olav Johannson and Jan Erik Nilsen | Comprehensive psychiatric service system | 0 + years | Overview of system

**Gausel Unit** | Rune Eliassen Psychologist Tron Gronnestad | Residential rehab and outreach support service Family support work | Residential rehab is mainly for people who have been ill for too long. (Mainly younger people under 30yrs) Will take up to two people with D&A issues | Similar model to CCU and MSTS in Victoria

**Sola Kommune Psychiatric Services** | Anne Karin Jacobsen Psychiatric nurse and Team leader | Clinical outreach support. Limited day program services. | | Long term supported housing physically attached to the clinic

**TIPS Family Program** | Anne Lise Oxnevad Psychologist | Multi-family work | TIPS participants and their families. (Must be a part of TIPS research – 1st onset of psychosis | Groups of five families meet each fortnight for two years

**Sandnes Kommune Psychiatric Services** | Bjarne Lemvik | Community based services including a day program, housing and outreach support. Also looks at health promotion/ reducing stigma | 18 years and older | A strong rehabilitation approach.

**Sandnes Kommune Mental Health House** | Eilert Hjornevik Consumer Coordinator | Consumer run drop in centre | Any person who has experience a mental illness in Sandnes Kommune | An inspirational place where everything from the renovation of the house to the newsletter are instigated and completed by consumers.