



Australian Government

CHCMHS003 Provide recovery oriented mental health services

Release: 1

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Modification History

Release	Comments
Release 1	This version was released in <i>CHC Community Services Training Package release 2.0</i> and meets the requirements of the 2012 Standards for Training Packages. New unit.

Application

This unit describes the skills and knowledge required to work collaboratively in providing services to implement a range of strategies as part of recovery oriented service provision for people with mental illness.

This unit applies to work with people living with mental illness in a range of community services work contexts.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian/New Zealand standards and industry codes of practice.

Elements and Performance Criteria

ELEMENT

PERFORMANCE CRITERIA

Elements define the essential outcomes

Performance criteria describe the performance needed to demonstrate achievement of the element.

1. Share and collect information to collaboratively inform the plan for recovery

- 1.1 Work in a recovery oriented framework that respects the person's experience, culture and unique recovery journey and the agreed recovery alliance relationship
- 1.2 Use a collaborative approach to discuss and determine information to be collected and sources of information to be accessed
- 1.3 Explain any organisation or program requirements including the commitment to access and equity, and limits to confidentiality
- 1.4 Obtain consent from the person according to

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organisation policy and procedure

1.5 Gather and document information from the person and other agreed sources to explore and clarify the person's preferences, meanings and needs

1.6 Apply best practice principles, if formal assessment is to be conducted, and work within organisation policy and procedures relating to assessment protocols

1.7 Together identify the range and potential effects of social and other barriers that are impacting on the person

2. Facilitate collaborative planning process for recovery

2.1 Work collaboratively to develop a plan for recovery and transition based on the person's choices, preferences, values, needs and goals and discuss different planning options and tools

2.2 Facilitate planning sessions using effective communication strategies in a manner that respects the person as their own expert, fosters their strengths and supports them as the driver of their recovery journey

2.3 Discuss and confirm the person's choices for personal wellness, development of self-efficacy, cultural requirements, values, meanings and purpose in life

2.4 Work collaboratively with the person to identify strategies and priorities to achieve goals including self-advocacy strategies and transition beyond the service

2.5 Identify possible barriers or risks with the person and the strategies and/or other people who can assist in responding to or overcoming these challenges

2.6 Develop and document personal wellness plan, risk plans or other plans to meet the person's priorities, as appropriate

2.7 Work collaboratively with the person to identify and balance duty of care and dignity of risk considerations whilst promoting independence from service

2.8 Identify and document the person's and worker's roles and timelines for action

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Performance criteria describe the performance needed to demonstrate achievement of the element.

3. Collaboratively implement plan for recovery

3.1 Discuss with the person their interest and readiness to initiate their plan for recovery

3.2 Undertake service actions as agreed in the plan in a timely manner

3.3 Facilitate access to information, resources and education about opportunities and service options relevant to the persons aspirations

3.4 Support person's decision making and self-advocacy

3.5 Support person's positive risk taking and resilience building

3.6 Maintain regular contact with the person, and be available to offer support and follow up on actions

3.7 Maintain records and progress notes in collaboration with the person

4. Develop and maintain effective working relationships with care support network

4.1 Determine with the person who else they choose to involve in their recovery process and the roles they want them to play

4.2 Obtain consent specifying what information can be shared with specific members of their care network and the circumstances in which the information can be released

4.3 Identify the information and support needs of family, carer/s and friends

4.4 Establish rapport and build an effective working relationship with relevant members of the care network

4.5 Provide and communicate information so that it is readily understood by members of the care network

4.6 Work from a strength based approach and communicate in a manner that respects the rights, dignity, choices and confidentiality of the person with the mental health condition while facilitating the care network to support the person

4.7 Facilitate support, training or services to family, carer/s and friends based on identified needs

ELEMENT**PERFORMANCE CRITERIA**

Elements define the essential outcomes

Performance criteria describe the performance needed to demonstrate achievement of the element.

5. Support person during challenges

5.1 Respond proactively to potential obstacles, challenges and barriers that arise, working with the person to identify ways to proceed and to reduce the likelihood of occurrence

5.2 Maintain an empathic, supportive and hope inspiring approach as challenges occur seeing challenge as part of the recovery journey and sources for learning

5.3 Respond promptly, positively and supportively to person in distress or crisis and support access to required services

5.4 Respond promptly to de-escalate potential incidents or risks and promote safety

6. Collaboratively review the effectiveness of the plan and support provided

6.1 Review recovery plan and alliance regularly with person to ensure continued relevance and effectiveness

6.2 Gather feedback from the person at key milestones about the effectiveness and progress in implementing their recovery plan

6.3 Identify new directions and areas for change in the recovery plan and amend plans and transition strategies

6.4 Continue implementation and review cycle for the recovery plan until outcomes have been achieved and no further service or support is required

6.5 Gather and respond to feedback from the person on their satisfaction with the service and support provided

6.6 Reflect on work practice and feedback and identify opportunities for enhancing empowerment and improved processes

Foundation Skills

The Foundation Skills describe those required skills (language, literacy, numeracy and employment skills) that are essential to performance.

Foundation skills essential to performance are explicit in the performance criteria of this unit of competency.

Unit Mapping Information

No equivalent unit.

Links

Companion Volume implementation guides are found in VETNet -
<https://vetnet.gov.au/Pages/TrainingDocs.aspx?q=5e0c25cc-3d9d-4b43-80d3-bd22cc4f1e53>