Appendix 2: Detailed description of types & models of community-based & clinically operated residential rehabilitation for people affected by schizophrenia & related disorders in Australia.

Service type	Focus / objective	Service model	Timeframe	State	Physical environment	Philosophy of Care	Treatment and support	Source
Community based residential care	▪ Deinstitutionalisation of people with SPMI ▪ Permanent residence ▪ Accommodation, rehabilitation and support	Community Residences	1994-early 2000s	NSW	▪ Group homes (3x 10-bed), with single or twin share bedrooms and shared kitchen and dining facilities, OR apartment block (x1) with four self-contained units. ▪ Provision of indoor and outdoor recreation areas. ▪ Walking distance to shops and public transport.	▪ Intensive case management through an adapted model of Assertive Community Treatment ▪ Normalisation through treatment in a residential setting ▪ Rehabilitation focus	▪ 24-hour Multi-Disciplinary Team (MDT) support initially, with a step-wise reduction over time ▪ Individualised programs: living skills, planning for more independent living (e.g. budgeting, medication self-administration, vocational engagement) ▪ Prompting, modelling, task analysis, practical assistance and education ▪ Case managers facilitate access to external resources in the community.	[1-3]
		Community Care Unit	1996-early 2000s	VIC	▪ Purpose build cluster-style housing with up to 20-beds, providing a 'home-like environment' built close to shops and public transport. ▪ Provision of outdoor recreation and quiet spaces, as well as communal rooms for group activities, described ▪ Early iterations provided individual bedrooms and shared bathroom, kitchen and living areas to small groups of residents. ▪ Later iterations described mixed residential configurations including self-contained single-occupancy, dual occupancy and shared units	▪ The application of case management to a residential psychosocial rehabilitation program integrating clinical care and disability support ▪ Emphasis on accessing and utilising community-based services and resources	▪ 24-hour nursing supervision available ▪ Primary focus of 'living skills therapy' and medication adherence/monitoring ▪ Absence of group-based rehabilitation activities emphasised ▪ Behaviour therapy as the only documented individual therapy	[4-10]
Transitional residential rehabilitation	▪ Rehabilitation ▪ Focus on SPMI ▪ Transitional residential support		Early 2000s+	VIC QLD		▪ Transitional support over 6-24 months, but with acknowledgement that some consumers may require further extended care ▪ Recovery-oriented ▪ Strengths-based ▪ Rehabilitation focussed ▪ Individualised care planning	▪ 24-hour clinical staff support availability ▪ Individual therapeutic focus including: CBT; living skills development; structured leisure and physical activities; and evidence-based therapeutic groups. ▪ Provision of psychoeducation and support to carers, and promoting continued links between consumers and their carers ▪ Not authorised mental health services	[4, 11-16]
	[11, 12, 17]		2014+	QLD			▪ As above but with the additional availability of an integrated staffing configuration where Peer Support Workers occupy the majority of roles.	[11, 12, 17]
		Hawthorne House	2006-2009	WA	▪ Stand-alone 16-bed converted community hospital	▪ Psychiatric rehabilitation ▪ Commitment to recovery ▪ Biopsychosocial approach	▪ Maximum of 16 weeks of active structured psychiatric rehabilitation focussed on transitioning 'rehabilitation ready' hospitalised inpatients ▪ MDT (Occupational Therapy, Nursing, Social Work, Art therapy, Medical)	[18]
		Community Rehabilitation Centre	2007+	SA	▪ Three sites including 2 purpose-built (outer-urban location) and one re-purposed building (inner-urban location). ▪ Shared and individual living units are available, each with individual bedrooms.	▪ Recovery-oriented rehabilitation, including focus on prevention, early intervention, and voluntary participation ▪ Emphasis on viewing the person in the context of their family and significant others.	▪ 24-hour staff support, with staffing configuration including clinical and non-clinical (including peer) specialists ▪ Working in partnership with the community mental health team. ▪ Active and goal focused rehabilitation program including therapeutic interventions, skills development, building/rebuilding personal networks, and fostering community links ▪ Average residence <6 months ▪ Not Approved Treatment Centres	[19-21]
		Community Recovery Program	2014+	VIC	▪ 22-bed purpose-built unit, standalone co-located with a hospital service	▪ Recovery-focused rehabilitation ▪ working within a philosophy of 'home' and 'community', recovery and social inclusion, and consumer participation. ▪ Emphasis also on consumer-centred care, and family/carer involvement.	▪ Partnership model with clinical care provided by nursing staff employed by the health service and 'community health practitioners' with expertise in recovery-oriented psychosocial rehabilitation employed by a non-government organisation. Peer and family/care workers are included in staffing profile. ▪ Focus on living skills development, psychoeducation, recreation and fostering links with the community. ▪ Group programs are available.	[22-24]

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