View from the peak

A quarterly publication from the Mental Health Coordinating Council Winter 2013

A truly integrated approach to mental health

MANY WILL have wondered about allocation of $1.8 million for a mental health Integrated Service Model in the most recent state budget. The broad concept of a cross sector, integrated and co-located service model has been around for many years but this allocation of funding has made it possible to at last trial the concept. An EOI is currently out for two pilots of the model to be established in the greater Sydney area.

The proposed model is innovative and with genuine partnership and commitment underpinning its operation, has the potential to revolutionise the experience of consumers and carers seeking support for mental health conditions.

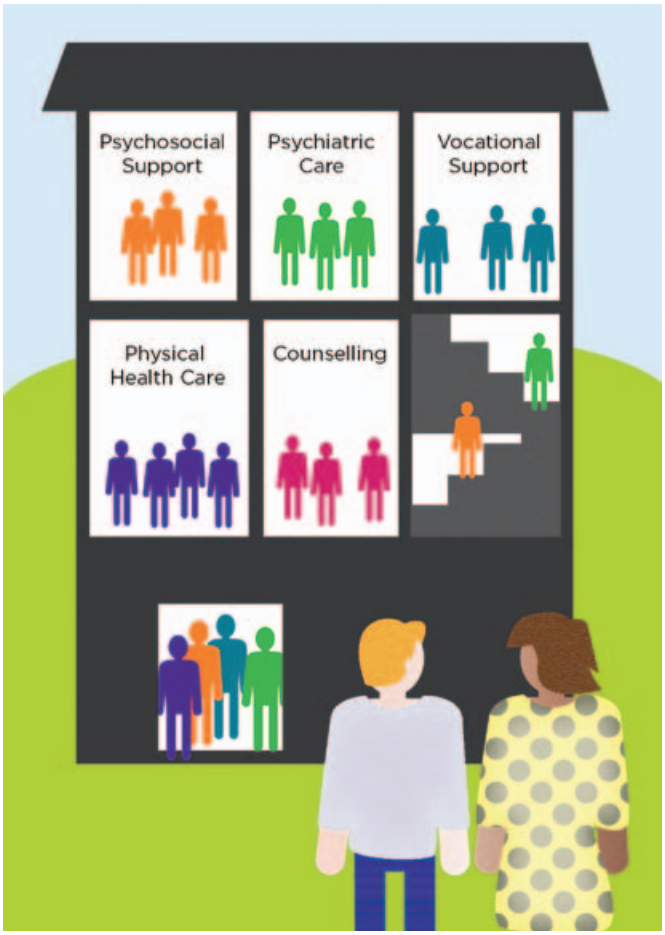
It makes sense that the structure of services fits with current understanding of what supports the recovery of people with mental health conditions. In addition to choice and self-determination, these include:

- physical health and wellbeing
- management of psychiatric symptoms
- worthwhile occupation and employment
- a good home and positive relationships with family, friends and others.

Most services are designed to provide only one or two of these functions and workers must then attempt to make referrals or create partnerships with other providers to organise what the person needing support requires. Frequently there is not a clear and agreed approach communicated between the service user and the public, community sector and private practitioners involved in their treatment and support. For the consumer or carer this disjointed and piecemeal approach can be frustrating, stressful and traumatic as they are bounced around the system or simply can't access what they need.

Under an integrated and co-located service, symptom management and medication, physical health screening, psychological counselling, vocational support, social and leisure connections, family interventions, housing support and peer support and advocacy are some of the service choices able to be built into a single integrated support plan.

Under the Integrated Services Model the reality of 'no wrong door' is more fully achieved. People seeking support enter a service where there is a coordinated assessment and plan which encompasses the breadth of issues that brought them to seek help. Co-location



Under an Integrated Service Model, there is 'no wrong door'.

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means less system navigation for consumers and carers; a more holistic response and more choice. For practitioners it means clearer role delineations, and better access to and more understanding and respect for other skill sets. Better coordinated and applied use of state and commonwealth funding streams is a further benefit of the Integrated Service Model.

The proposed model is innovative and with genuine partnership and commitment underpinning its operation, has the potential to revolutionise the experience of consumers and carers seeking support for mental health conditions.

Organisations tendering for the lead agency role will be needing to clearly articulate a shared clinical or practice framework and this will be key to the success of the model. The EOI application is clear that a non-government organisation is to take on the lead agency role. Whether this is a community organisation, medicare local or a private provider appears to make no difference to government.

Demonstrated experience working in successful partnerships and consortia, holistic recovery orientated service approaches and a track record of sound systems and financial management will be the key to any successful EOI. Additionally, clear explanation of the important and exciting innovation that can come from the model in better supporting consumers and carers; developing the skills and motivation of practitioners and making the best use of mental health dollars will also likely be well received.

These pilots will need passionate advocates to meet the inevitable challenges and lead NSW into a properly integrated way of supporting people experiencing mental distress. MHCC congratulates Minister Kevin Humphries for championing piloting of this approach in NSW.

Best wishes

Jenna Bateman
Chief Executive Officer

MHCC ACTIVITIES – AT A GLANCE

Key Projects – details at www.mhcc.org.au

- Physical Health
- Aged Care
- Medicare Locals
- Community Mental Health Drug and Alcohol Research Network (CMHDARN)
- Social Enterprise
- MHCC Policy Resource
- Service Coordination Strategy
- CAG & MHCC 'Recovery Resource' Project (ROSSAT)
- Data Management Strategy
- National Directions in Mental Health Workforce Development
- Sector Benchmarking Project
- National Outcome Measurement and Minimum Data Set Projects
- Supervision practices in MH community managed organisations
- Mental Health Rights Manual – 2013 updates
- Psychological Injury Resource
- Practice Supervision
- Mental health and Children of Prisoners
- Practice Placements Projects
- Trauma Informed Care & Practice

MHCC on behalf of CMHA:

- National Outcome Measurement & Minimum Data Set Projects
- Australian Commission on Safety & Quality in Healthcare National Standards for MH Services implementation
- Peer Work Qualification Development

Submissions:

- Australian Commission on Safety and Quality in Health care: Health Literacy Consultation
- Input NMHC Literature Review "Supporting young people with a mental illness in the transition from education into the workplace" HETI/Sydney ICTN (HWA)
- NSW Mental Health Act 2007 review: Report for NSW Parliament
- Final Report on the Practice Placement Project was submitted

MHCC facilitated and/or presented at the following events:

- Partners In Recovery Reference Group Meeting 31/07/13
- NSW Mental Health Commission 20/06/13
- Australasian Mental Health Outcomes and Information Conference 13/06/13
- CMHDARN Webinar 05/06/2013
- CMHDARN Research Forum 26/6/13
- A successful provider response to the personalisation agenda in the UK by Peter Gianfrancesco 28/6/13

From grants to tenders

What this means for community managed mental health organisations funded by the Ministry of Health

SEVERAL broad across-government reviews have been conducted in the last few years identifying the need for improved administration of government funding to NGOs.[1,2] Particular focus has been on the governance, transparency, efficiency and effectiveness of funded services; improved value for money in delivery of direct services; better alignment of services delivered against state wide priorities and a reduction in the number of NGOs. The NSW Ministry of Health has also been undertaking several distinct reviews about how it 'partners' with the non-government sector to deliver services.[3,4,5]

The Ministry is currently in the process of moving to implementation of contestable and open procurement processes for services and to decrease the issuing of 'grants' through the NGO Grant Program. Put simply this means services will be competitively tendered and grants will become largely a thing of the past. Capacity to provide one-off, time-limited grants will remain, but will be the exception rather than rule. There will be no grants 'program' as we have known it.

It's important to understand that when government refers to NGOs it is referring to all service providers that are 'not government'. This includes private providers, Medicare Locals and community organisations. The government has taken a position that the governance and business models of these distinct sectors are not relevant to their choice of providers.

The Ministry has recently determined to provide a longer lead in time for this new approach than originally announced. Most services/programs currently delivered by NGOs through grants will now be transitioned to fee for service contracts through open, contestable procurement in 2014/15.

How the tenders will be structured will be based on the Ministry and LHDs identification of needs and priorities. Tenders will be developed to align with their understanding of what these priorities are. This may include same or similar services which are currently provided by NGOs, as well as new or different services designed to meet areas of need not currently being met. The timeframe for this change to how services are funded has recently been extended to ensure the disruption to people accessing services is kept to a minimum and to ensure service configurations are based on evidence as to what service are needed and where.

The extended timeframe now in place will allow the strategic planning process currently underway by the NSW Mental Health Commission (MHC) to incorporate a planned and considered approach to service delivery across the public, private and community sectors. The Commission has, as its primary aim, delivery of a NSW mental health strategic planning framework to government by June 2014. Determining what services should be delivered and who is best placed to deliver them should encompass the whole mental health service system – it makes little sense to review a part of the system without reference to the whole. MHCC supports the Ministries decision to extend the timeframe.

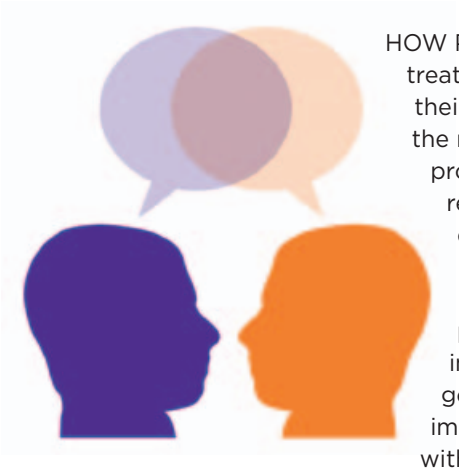
All services currently funded under the NGO Grant Program will have received letters informing them that their grant will cease as of June 2014 and that a contestable tendering process is intended to take place in the second half of 2013. Letters stating the timeframe has been extended to 2014/15 will be sent out in the next few weeks.

However the need to ensure readiness for participation in tender processes should remain high on the agendas of all community organisations. NGOs should be considering:

- Alignment of services with the NSW 2021 State Plan and NSW Health priorities.
- Strategic and operational partnerships including consortia participation, collaboration, co-location, integration and service consolidation across the sector.
- Capacity and readiness to deliver services to specific population groups and across geographic regions.
- Strong governance and quality systems.
- Sound accountability, financial management, evaluation and reporting infrastructure.
- Demonstrated evidence base for the organisations approach to service delivery.
- Consumer and carer participation.
- Ability to demonstrate outcomes for service users.
- Clear and detailed costing frameworks.
- Demonstration of value adding. Organisations that can demonstrate the value add they make as a result of existing partnerships, intellectual property, real estate and complimentary financial and in-kind contributions, for example, will increase their advantage in the competitive tendering process.

(See page 16 for references.)

Open Dialogue – makes absolute sense



HOW PEOPLE experience treatment and support from their very first interactions with the mental health system has profound impacts on their recovery and their future engagement with the system. *Open Dialogue* is an approach to supporting people which arose in Finland in the 1990s and which has gone on to demonstrate important outcomes for people with psychotic conditions including reduced use of medication, fewer hospital admissions, greater participation in employment and education and lower reliance on disability support benefits.

The basic premise of the *Open Dialogue* approach is to engage with the person experiencing psychosis in the context of their family and social networks, supporting practitioners and others the person feels they would like involved. This social and therapeutic network meets within 24 hours of the expressed need for assistance (preferably in the person's home) with the person experiencing psychosis participating in the meeting. All management plans and decisions are made with everyone present. Responsibility for the process rests with the same team whether in a community or inpatient setting. The general aim is to generate dialogue to construct words for the experiences that occur when psychotic symptoms exist.

The voice of the person experiencing psychosis is seen as one voice among others. The aim in *Open Dialogue* is not to diagnose but to create a joint space where there is the potential for new ways of relating and understanding. Various therapeutic approaches can become part of the process depending on specific issues arising and agreed options; in Open Dialogue the process of exploring treatment and support directions amongst the 'network' is equally if not more important than specific therapy approaches.

Open Dialogue has been used primarily with young people experiencing psychosis but has the potential for much broader application. In Northern Europe there is widespread recognition of the value of Open Dialogue and it has dramatically changed how some mental health services operate.

This brief overview does not do justice to the research or process of the approach. A recommended article can be found in Jaakko Seikkulai et al. *Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies*. Psychotherapy Research, March 2006; 16(2): 214_/228. Inside Out and Associates Australia recently hosted Open Dialogue Finnish nurse practitioner Jaana Satu Castella at a forum in Sydney – www.insideoutconversations.com.au.

Further information is available on the SFNSW website at: www.sfnsw.org.au/Awareness---Education/Open-Dialogue-Program.

Review of the NSW Mental Health Act 2007: Report for NSW Parliament

A SUMMARY of Consultation Feedback and Advice was recently published in response to the Review of the *NSW Mental Health Act 2007.* The Summary required the Minister to review the Act 'to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives'. This review had to be undertaken five years after the Act was assented to (s 201).

The outcomes of the Review indicate that the policy objectives of the NSW Mental Health Act 2007 remain largely valid and provide an appropriate legislative framework for the mental health system. The review summary stated that:

'...the structure of the Act is robust, and on balance the content is supported. However, a number of issues have emerged from the consultation, and while some relate more to the implementation of the legislation (rather than the Act itself), there are opportunities to amend some sections of the Act to reflect contemporary language and emerging evidence, improve operational clarity and alignment with other legislative approaches in relevant areas'.

In view of this statement MHCC determined to provide its members with feedback on how

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aligned the recommendations are to the issues they had identified in their submissions to the Review. The Report for NSW Parliament: May 2013 is available at: www.health.nsw.gov.au/mhdao/Documents/Review-of-the-Mental-Health-Act-2007.pdf

MHCC's original submission drew attention to the language used in the legislation which we proposed could be improved to reflect recovery principles. The NSW Act refers to providing for the 'care, treatment and control' of mentally ill and disordered persons. We are pleased to note the review's consideration of embedding recovery principles into the principles of care and treatment in the Act.

MHCC also advocated that 'supported decision-making' become a principle to promote progressive thinking with regards to alternative care options involving substituted decision-making. In-depth analysis is required of the possible models of involuntary provision of treatment, the possible unintended consequences of any changes, and the likely resource implications. This would include monitoring and evaluation of the implementation of a supported decision making model in other jurisdictions to inform any future possible approach in NSW.

The review items do not reflect all the issues raised in MHCC's submission, however, we have provided a summary list that addresses the items contained in the Report to Parliament, which is available at: mhcc.org.au/media/8727/sub-issues-under-nswmhact07.pdf

MHCC's original Submission to the Discussion Paper: Issuers arising under the NSW Mental Health Act 2007 is available at: www.mhcc.org.au

For any further information concerning this review please contact Corinne Henderson, Senior Policy Officer at corinne@mhcc.org.au

Activity based funding and CMOs

AMID THE major health reforms underway you may have missed the transition occurring from traditional block-funded health system toward the Activity Based Funding (ABF) system being implemented for Local Health Districts across NSW. ABF is the method through which the Commonwealth Government will provide funding of around $175 billion to state and territory health systems over the next 16 years.

Activity Based Funding is a method where every procedure or treatment undertaken by a public health service is attributed a nationally-set fee which is paid to the LHD each time a service is provided. It is governed by two national agencies: the Independent Hospital Pricing Authority (IHPA) and the National Health Performance Authority (NHPA). It was initially designed as an attempt to more equitably fund hospital services, however as it evolved in the Australian context the 'sub-acute' and 'non-acute' areas of health appear to be making their way into scope. This brings up the issue as to whether LHD funding for community managed services will also need to be funded and reported on a per-activity basis. There is no clear answer to this yet, though it is looking likely that at least some funding will be sourced through ABF – though these may be programs mostly related to 'post-acute' activities (e.g. step-up/step-down, some residential services).

Many LHD activities have already begun being funded through ABF. Mental health is an exception to this, primarily because the IHPA initially intended to use the Diagnostic-Related Groups (AR-DRGs) categorisation system across most health disciplines. While DRGs have been found to be highly predictive of activity cost in most physical diseases, they are renowned for their poor predictive capacity in mental health and alcohol/drug disorders. For this reason the IHPA has decided to develop a separate care type for mental health and has delayed the implementation of ABF to mental health while they develop a more reliable method of classifying mental health activity cost.

Due to the fact that growth funding is now tied to ABF, which is heavily focused on hospital-oriented services, there is some concern that there will be a strong incentive to provide more mental health services on hospital grounds to make the most use of ABF. Some progress has been made in developing community-based proxies for hospital related care items; however this issue is substantial and will continue to be a concern until clearer guidelines are produced.

In the meantime there are implications for CMOs in terms of becoming administratively ready for funding that needs to be measured on a per-activity basis. This is an even finer level of detail than the per-package level of reporting that will be needed to access funding through DisabilityCare Australia. Organisations developing their capacity to keep track of discrete service activity for clients will need to keep a keen focus on future activities in the ABF space.

Creating tomorrow's workforce today: MHCC practice placement project

IN THE first half of 2013, MHCC was funded by Health Workforce Australia (HWA) via the NSW Health Education and Training Institute (HETI) and Sydney Interdisciplinary Clinical Training Network (ICTN) to undertake the 'Practice Placements Project in the Community Managed Mental Health Sector'.

The primary objective of the project was to meet the priority student placement need in mental health by establishing relationships between higher education providers (HEPs) and non-government mental health community managed organisations (CMOs) to increase professional entry practice placement opportunities in the following disciplines:

- Nursing
- Medicine
- Psychology
- Occupational Therapy
- Social Work
- Nutrition/Dietetics, and
- Exercise Physiology.

The aim of this project was to explore, increase and provide quality practice placements in the community managed mental health sector for potential new entrant health workers. The long term goal of this project is to contribute to the development of the future mental health workforce. To achieve this goal, it is essential in the short term that students are exposed to current trends and practices and a diverse range of work roles within a mental health setting. For students to consider mental health as a future career pathway the number and quality of placements must be increased.

"Community managed mental health sector placements ... allow students to understand that people's lived experience (of mental illness) is the way to work ... they need to be supported to their own definition of recovery, not one imposed by clinical services."

Dr Cathy Kezelman
Consumer Representative
President, ASCA and MHCC Board Member

Essentially, we 'piloted' interprofessional 'clinical'/practice placements at four host organisations between 2 April and mid-May: UnitingCare Mental Health; RichmondPRA; Neami, Newtown Neighbourhood Centre. The students were from across a broad range of disciplines within three universities – Sydney University, the University of Western Sydney and the University of Notre Dame.

The key activities/deliverables of the project are:

- a Scoping Paper – which includes a literature scan, analyses results of a survey and informs on models relevant to community sector student practice placements.
- a Placement Guide targeting CMOs – providing placement guidelines and more than 20 resources that support practice placements (ie, templates and other supporting documents).
- a Placement Listing targeting HEPs – including detailed information about more than 20 CMOs delivering mental health programs across NSW that are able to host practice placements.
- a Practice Placement Pilot
- project Evaluation
- Project Report – including research evaluation findings for the practice placement pilots, details the project outcomes, and proposes recommendations to build on the work undertaken.

> **For programs like this to succeed, it's important to have … an organisation that can bring together employers and educational institutions. There (also) needs to be greater recognition … that workplaces do provide sites for learning … they are not just a site of service delivery.**
>
> **Professor John Buchanan**
> Director, Workplace Research Centre
> University of Sydney,
> School of Business

All of the project documents are available as an E-resource on the MHCC website: mhcc.org.au/sector-development/workforce-development/practice-placements.aspx

In addition, MHCC developed a webcast to reflect upon and share the project findings and recommendations. It includes a panel presentation/discussion, audience 'Q&A' session and an overview of the Placement Guide resources.

The Practice Placement Pilot was evaluated using an ethics approved research methodology and this work was undertaken by the Workplace Research Centre (WRC/University of Sydney). WRC also authored the final Project Report. It makes 12 findings and proposes 9 recommendations to help to shape future directions for building the number and quality of community managed mental health sector practice placements. The recommendations take a 'skills ecosystems' approach to creating more sustainable workforce development.[1]

Given, the ambitious timelines of the project, there were many challenges related to negotiating the varying placement requirements of the different universities and disciplines in an interdisciplinary context. Ultimately, a total of 22 students participated in the Practice Placement Pilot with some consenting to interviews with WRC to discuss their experience. WRC also interviewed host organisations and conducted an online survey of 24 university staff to explore issues related to practice placement capacity building.

We know that the future mental health workforce will look very different from that of today, especially as this relates to achieving self-directed preventative healthcare that is grounded in the social determinants of good health and well-being. Health Workforce Australia's recent '2025' reports predict shortages for nurses and psychiatrists working in mental health[2]. Australia needs more of these professionals as well as to consider reconfigured training curricula and job roles for them. All mental health workers – whether university or vocationally trained, and including peer workers – need improved skills to provide more effective person-centred recovery-oriented, trauma-informed and coordinated service delivery. The community sector exposes emerging health professionals to this type of practice and provides a holistic and more psychosocial counterpoint to that of acute and hospital based care.

Future priorities include enhancing the sector's interprofessional and work integrated learning practice supervision capacity and increasing understanding of the role of key regional drivers in increasing capacity for training places. A cost/benefit and productivity analysis is also recommended to further refine the proposed practice placement model.

In completing the project MHCC is well positioned to scale up structured approaches to training placements, and to continue to contribute to creating tomorrow's health and community service workforce today!

> **I think (the Placement Listing is) fantastic! We're constantly looking to provide new kinds of learning opportunities for students … it's so detailed about the programs are being run in different organisations … and requirements for students – it makes our job much easier.**
>
> **Professor Lindy McAllister**
> Associate Dean –
> Work Integrated Learning
> University of Sydney,
> Faculty of Health Sciences

1 Finegold D. (1999). Creating self-sustaining, high-skill ecosystems, Oxford Review of Economic Policy, Vol 15, no.1.

2 http://www.hwa.gov.au/health-workforce-2025

What's happening to Aged Care – reform update

POOR MENTAL health need not be a product of ageing, however, older people can be vulnerable to mental health conditions. Some people develop conditions as they age, while others grow older with a mental health condition that developed earlier in their lives.[1] Anxiety and depression are particular risk factors for older people exacerbated by poor physical health, dementia, disability or bereavement.

Consumers should not be discriminated against when accessing a diversity of community services or residential aged-care facilities. However, suitable care within the system is inconsistent as workers often do not know how to support people with mental health conditions. Services tend to respond to dementia or 'behavioural' issues rather than responding to individual needs. MHCC has been working with stakeholders to bridge the gaps and built capacity through training opportunities that promote recovery-oriented person-centred care.

Anxiety and depression are particular risk factors for older people exacerbated by poor physical health, dementia, disability or bereavement.

The COAG National Health Reform 2010 process includes major reforms still underway with aged care policy and funding responsibilities shifting to a national approach. Until 2015 access to most services will remain mostly unchanged, thereafter the Commonwealth will take full responsibility for people over 65 years of age. A no wrong door approach is the aim until reforms are embedded.

The *Living Longer Living Better* (LLLB) National reforms released in 2012 aims to improve coordinated care for older people in their homes and aged care settings. . LLLB includes an expansion of the packaged care programs (previously CACP, EACH/D) – now known as Home Care Programs with four levels of packages – the first tranche being available from August 2013. Keep up to date on developments at: www.livinglongerlivingbetter.gov.au/.

Under these reforms, the existing Home and Community Care (HACC) Program has been split into the Commonwealth HACC Program and NSW Community Care Support Program (CCSP). The Commonwealth program is for people over 65 and the NSW program for people under 65 (for Aboriginal or Torres Strait Islander people +/- 50 years) with a permanent functional disability and their carers, who live in the community and are at risk of premature or inappropriate admission to residential care. There will be an increase in packages to assist more people to live at home. They will replace current Home Care packages and must be offered to consumers on a Consumer Directed Care (CDC) basis.

My Aged Care will gradually become the main entry point into the aged care system, providing information and referrals. From 2014 clients should be able to complete an aged care needs assessment over the phone. Information is currently available via: www.myagedcare.gov.au or on 1800 200 422.

Accessing services now...

Existing Home and Community Care (HACC) services are still available until 2015. Specialist mental health services in Local Health Districts (LHDs); specialist clinical services and a stream of public mental health services are available in addition to health and community services, both community-based and residential.

The Aged Care Assessment Team (ACAT) still provides advice and information on care options and referrals to residential or community care services. Your doctor can refer you to an ACAT or contact them directly on 1800 200 422.

Commonwealth Respite and Carelink Centres (CCRC) still provide local information for older people, people with disabilities, carers and service providers. For more information call 1800 052 222 or www9.health.gov.au/ccsd

There are limited residential facilities specialising in older people with mental health conditions. Examples include: Uniting Care – Annesley House; Catholic Healthcare – Frederic House, Salvation Army – Montrose Aged Care, and Mission Australia – Annie Green Court.

The state Specialist Mental Health Service for Older People (SMHSOP) program provides multidisciplinary outpatient assessment and community services for people 65 years and over with a diagnosable mental health disorder or problem. Referrals are through the local Mental Health Service.

1 The National Ageing Research Institute (NARI), Benevolent Society. (2012) Supporting older people who are experiencing mental distress or living with a mental illness. Research to Practice Briefing 7, August 2012

Image courtesy of Sweet Peas

Change of provider for DBMAS

From 1 July 2013, the NSW Dementia Behaviour Management Advisory Service (DBMAS) program will be provided by HammondCare. NSW Health has been the provider of the Commonwealth DBMAS program in NSW since 2007, with DBMAS operating as a distinct yet integrated component of NSW Health Specialist Mental Health Services for Older People (SMHSOP) in Local Health Districts across NSW.

DBMAS provides clinical support for people caring for a person with dementia demonstrating behavioural and psychological symptoms of dementia (BPSD). These specialist services also need to be provided to older people and their families in an integrated way, in combination with primary health and aged care services, community support services, hospital services and the housing and residential aged care sectors. To date DBMAS has been integrated with SCHMOPs which has supported service integration with medical back-up and referral to a range of services.

The NSW Ministry of Health, SMHSOP and HammondCare are currently working together to ensure a smooth transition to the new DBMAS service delivery arrangements and transfer of care for clients and their carers and families over the coming months. HammondCare are now taking referrals through the DBMAS 1800 699 799 telephone line. Information can be also found on the national DBMAS website: www.dbmas.org.au

Is there a relationship between early onset dementia and people with mental health conditions?

WITH a growth in numbers of people living longer in the general population, the number of people with dementia is steadily increasing. In 2003 Access Economics (2003) presented age-specific dementia prevalence rates resulting in estimates of 162,300 Australians with dementia in 2002, 0.8% of the population. Applying these prevalence rates to estimates at that time of the growing Australian future population showed dementia reaching the half-million mark around 2041 and growing to 581,300 people by 2051, 2.3% of the then projected population.[2]

Whilst many epidemiological studies of Alzheimer's disease (AD), (the most common form of dementia) have been conducted, primary prevention is hampered by limitations in the knowledge and understanding about its risk factors. However, what seems a logical conclusion is that AD is more likely to have early onset in people with mental health conditions because the factors which are absolutely known to reduce risk of AD are a good diet, physical fitness and social relationships, not smoking, moderate alcohol intake and absence of illegal drug use.

As we have all become increasingly aware, people with mental health conditions tend to have lower life expectancy, age earlier, have poorer physical health and are more socially isolated. This is characteristically because of a number of factors including the negative impact of psychotropic medications, and the consequences of psychosocial disability which often lead to poor health outcomes.

Since little research evidence can be found in Australia or internationally, MHCC propose that this is an important area of research for our sector to promote, and we intend to raise this with university colleagues to ascertain where a study could most appropriately be situated. Ideally a study of service users across service settings to provide the link between mental illness and early onset of dementia would be most valuable.

MHCC welcome members views of this matter. Please contact Corinne Henderson with your comments at corinne@mhcc.org.au

2 Access Economics Pty Ltd, 2005. Dementia Estimates and Projections: Australian States and Territories Report for Alzheimer's Australia.

Unpacking the situation for people living with psychosocial disability:

Opportunities presenting through DisabilityCare Australia

MHCC HAS been funded by the NSW Mental Health Commission to explore and analyse the situation from a mental health and community managed mental health sector perspective at the Hunter National Disability Insurance Scheme (NDIS) transition launch site. This activity focuses on adults aged 18 to 64 years with some consideration also being given to the psychosocial rehabilitation and recovery support needs of both younger people and elderly adults also.

MHCC Senior Policy Officer, Tina Smith, will be working two days a week exploring the opportunities and barriers for people with high levels of psychosocial disability in addition to living with a mental illness. Such people typically present with other coexisting and complex health and social problems. The position is based in the Hunter.

The position/activity outcomes are to make recommendations to address how psychosocial disability is understood and included under DisabilityCare Australia (DCA) in terms of access and eligibility, existing community sector and public mental health programs, safeguards and workforce appropriateness. The project will also consider the wider DCA and health services interface, especially as this relates to the unmet physical health needs and high prevalence of substance misuse by people living with mental illness. The project learnings will also contribute to the national discourse regarding the situating of mental health within the NDIS. The activity will conclude with a final report summarising activity undertaken and project findings with related recommendations for strengthening the situation of mental health within the NDIS.

Tina has begun the process of meeting local MHCC member agencies to better understand their experiences and needs. Former boarding house residents with mental health issues who were successfully transitioned ten years ago into supported accommodation and that access community based activities will be among the first of the existing clients to transition to DCA.

In the first week of the launch there were 360 new clients referred to DCA and their year one capacity is for 400 new people only. It is unclear whether the program will be wait list (first in first served) or priority of access (on the basis of relative need which is Disability Services Act best practice). Hunter New England Mental Health reports a minimum of 50 referrals to DCA since the July 1 launch. These are now being processed and the assessment outcomes and eligibility decisions will be closely monitored.

Early discussions indicate that there is a likely need for a range of human service workers to much better understand the similarities and differences between acute episodes of mental illness and psychosocial disability and how these may co-exist.

Early discussions indicate that there is a likely need for a range of human service workers to much better understand the similarities and differences between acute episodes of mental illness and psychosocial disability and how these may co-exist. For example, people who are frequently acutely mentally unwell but have no or little residual disability when well are typically not going to be NDIS tier one eligible.

The work that occurs at the Hunter launch site over the next three years will help to inform both NSW and national directions for people with high levels of psychosocial disability and the community organisations that provide services to them. It is estimated that at full rollout, 57 thousand Australians living with psychosocial disability will benefit from DCA services and 19 thousand of these may be from NSW.

Tina will be presenting on issues arising from the DCA/NDIS work occurring in the Hunter during MHCC's August Regional Forums and you are encouraged to attend. MHCC needs to have a good sense of impacts upon, and sector development needs in response to, NDIS and this knowledge continues to be acquired and consolidated; especially as this relates to reconciling essential philosophic differences between the mental health and disability sectors with regard to recovery oriented practice.

Consumer and carer peer work qualification development project

THE PEER workforce is arguably the fastest growing workforce in mental health in Australia. Community managed organisations delivering programs across a range of service types, including family and carer support and education, are increasingly looking to the peer workforce as an effective adjunct to their existing workforce.

Based on international evidence and identified sector need, the Community Services and Health Industry Skills Council (CSHISC) developed the Certificate IV in Mental Health Peer Work CHC42912, to meet the needs of this emerging workforce.

On behalf of Community Mental Health Australia (CMHA), MHCC will coordinate the Peer Work Qualification Development Project funded by the National Mental Health Commission. Broad national consultation will inform the training and assessment resources for both the consumer and carer streams of the qualification. Completion of this project will allow Registered Training Organisations (RTOs) across Australia to deliver the Certificate IV in Mental Health Peer Worker, with all resources being freely available. Resources for the Consumer and Carer Peer Work streams are expected to be ready for distribution from mid 2014.

This project also acknowledges the need to support peer workers who are in leadership, mentoring or senior roles, and will develop an option for an additional training skills set in Peer Leadership.

To date the membership to the National Consumer and Carer Peer Work Qualification Reference Group has been finalised, with support from the National Mental Health Consumer and Carer Forum (NMHCCF). The reference group, which met for the first time in August, is comprised of Consumer and Carer Peer Workers, and representatives across Community-Managed, Public and Private Mental Health Services.

A National Technical Reference Group (NTRG) will also inform resource development, consisting of reference group members and other industry representatives particularly experienced in the development and delivery of qualifications.

The project's Management Steering Committee – including representation from CMHA and the National Mental Health Commission – met in early July to endorse a national survey which will be distributed to the sector and public for feedback during July and August. This feedback seeks to inform the initial development stage of the qualification resources, and explore aspects of peer work such as essential skills, core values and issues such as role conflict.

All interested parties are encouraged to contribute to the project by participating in the national survey at www.surveymonkey.com/s/peerworknational

If you would like further information about the Project, please contact Chris Keyes, Project Manager at chriskeyes@mhcc.org.au

MEET YOUR NEIGHBOUR COMES HOME

LOCAL organisations in the Inner West recently got together at a *Meet Your Neighbour* networking event hosted by the MHCC on their home grounds at Callan Park, Rozelle.

Despite the rain and tucked-away location of the hall, 40 people attended from a broad range of organisations with an interest in mental health. It was an informative morning with lots of enthusiastic conversation and exchanging of business cards. A typical comment, also given at this event was: "Great opportunity for info sharing, promotion and networking. Thanks!"

Attendees to these events recognise the value of making time for relationship building and hearing about unknown neighbours or new local services. People were appreciative of the information and connections they made or working relationships they built upon.

MHCC holds Meet Your Neighbour events around NSW to encourage organisations to meet, learn more about each other and find ways to work better together. Another comment made was: "Really useful event. Great to hear what other services do, programs and then to get in contact, etc." Feedback is always positive and has shown that these events are resulting in newly established

Continued over page >

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referral pathways, and consumers and carers being better matched to programs and services in their area.

MHCC invites member organisations to host a Meet Your Neighbour event. What better way to get to know your neighbouring services than to have them visit you, see where you are and meet your team?

How does being a host work? MHCC works with the volunteer host to send out the invitations manage responses and facilitate the event. The host provides a meeting space and a light morning tea. The get-togethers are about 2 hours, with plenty of time for networking.

For more information visit: www.mhcc.org.au or contact Stephanie Maraz: ph 9555 8388 x104 or email Stephanie@mhcc.org.au

CMHDARN Update

THE COMMUNITY Mental Health Drug and Alcohol Research Network (CMHDARN) activities continue to engage new and varied audiences, and this is reflected by increasing membership.

Earlier this year, the CMHDARN Steering Committee decided to focus 2013 CMHDARN activities on implementation science to try to promote the importance of embracing not just the idea of evidence into practice, but an understanding of the means by which your organisation can best implement the results of research.

On 5 June, our Rural Research Forum, Realising Research in Rural areas, focussed on both rural and remote issues and implementation science. Supported by the Centre for Rural and Remote Mental Health (University of Newcastle), there was an interesting mix of academic researchers, health staff and community based practitioners from across the Central West of NSW. The forum was opened by NSW Deputy Mental Health Commissioner and CMHDARN PRG member, Mr Bradley Foxlewin. The big picture rural context was well painted by our morning presenters, covering issues relating to consumer participation, the importance of doing business differently with Aboriginal people, the isolation and lack of alternative services in rural areas and the dominance of the research agenda by city based researchers. This was complemented by an afternoon workshop on implementation science which provoked an interesting discussion, and provided much food for thought.

This forum was followed up by the Reflective Practice webinar on 5 July where an informative and engaging presentation by Dr Robyn Mildon from the Parenting Research Centre addressed the issue of 'Incorporating research findings into service delivery – an introduction to implementation science.

The recent CMHDARN – Yarn, e-newsletter also featured suggested links to relevant implementation science readings and reports.

CMHDARN Project Officer, Deb Tipper, recently gave a presentation at the bimonthly NGO Research Forum, entitled 'Capacity building – a shared approach through CMHDARN'. Reflecting on activities to date and feedback surveys, Deb was able to share some of the project outcomes and emerging issues.

Outcomes

1. Impact on practice through forums, webinars and the Seeding Grants Program
2. Enhanced understanding of consumer issues
3. Positive networking experiences leading to better cross sector knowledge about coexisting issues
4. Enhanced relationships with academic researchers (see April FYI for full article)

Emerging research issues and challenges

1. Wide gap between workers and organisations in regard to research capacity and knowledge e.g. Challenges our focus for forums – trying to target appropriately the content
2. Differences between the two sectors, MH & AOD, in regard to engagement with CMHDARN activities e.g. Challenges content and promotion of activities
3. Lack of infrastructure within the CMO sector to support more proactive approach to research e.g. Accessible and affordable Ethics approval process for CMO organisations.

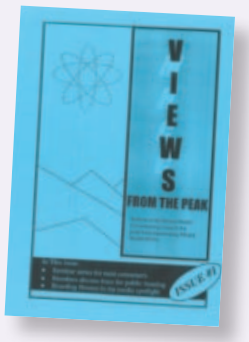
For further information and links to CMHDARN activities, visit www.cmhdaresearchnetwork.com.au/research-network-activities/

Happy birthday to us

IN 2013 The Mental Health Coordinating Council is celebrating 30 years working for mental health.

MHCC was founded in 1983 by a small group of specialist mental health service providers, including:

- Aftercare Association
- ARFMI
- GROW
- Life Line Sydney
- NSW Association for Mental Health (now MHA)
- A nominee of the Pala Society in Australia
- Psychiatric Rehabilitation Association
- Richmond Fellowship of New South Wales.



Humble beginnings. View From the Peak issue #1 August 1996

MHCC's membership has since mushroomed to 200 organisations and individuals across a diverse range of not for profit community organisations reflecting the growing understanding that mental health 'is everybody's business'.

MHCC policy and promotions staff are currently assembling an in-depth history of MHCC and the community mental health sector, highlighting developments, challenges and achievements from the past 30 years. This document is scheduled for release later this year.

MHCC's WEBSITE is also getting dressed up to celebrate our 30th

Finding what you need has never been easier with MHCC's new website design launching this month. In line with MHCC's strategic plan projects, activities, links and resources have been divided into four key areas:

- MHCC Home – for information about what we do, why we do it, our members, our structure, upcoming events and updates from the sector.
- Policy, Advocacy and Reform – for information about our leadership role, how we represent our membership, and how we seek to improve, promote and develop quality mental health services for the community.
- Sector Development – for information about our partnership development and research projects, capacity building resources, and how we are developing the tools you need.
- Learning and Development – for information about our wide range of accredited and professional development training.

Finding MHCC resources

Each of the four sections contains a Resource A-Z for quick access to submissions, templates, reports and publications.

Explore and share www.mhcc.org.au today.

MHCC activities are now divided across four areas, each with their own clear navigation menu to make finding what you need, when you need it a breeze.

ONE80TC – Teen Challenge NSW

ONE80TC has been part of the NSW community for over 35 years, providing long-term residential treatment and rehabilitation services for young men (aged 18-35) wanting to overcome addiction and other issues that impact their lives.

CENTRE Manager Gail Davies explains more about ONE80TC's approach:

'We don't pretend to be able to change a person's past. What we can do is try to understand what lies at the core of the presenting issues and help people find the physical, spiritual and emotional strength to face life's challenges head-on and come out on top in the future.'

On life skills training:

'We believe that people with jobs have greater self-esteem and confidence.'

On teamwork:

'We strongly believe in teamwork, and the importance of each participant's role on the team. Our hope is that they will build support structures and friendships that will last for a lifetime.'

On family reconciliation:

'People who are caught up in destructive lifestyles often wreak havoc on their relationships with family and friends. Through counselling and guidance the ONE80TC team aims to help families reconnect.'

On health professionals and counselling:

' Our [staff] are committed to restoring hope and stability in the participants' lives, and are passionate about helping them along the journey of recovery. Through weekly one-on-one and group sessions, participants are given the chance to address some of their previous hurts. We also provide relationship counselling for those who are married or with partners.'

Central to ONE80TC's approach is recognising that people are emotional, physical and spiritual beings, and a holistic approach is required to support them during their recovery journey. ONE80TC's vision is to help people put their lives back on track by providing support, direction, education and heartfelt commitment.

Participants residing at ONE80TC start their recovery journey by participating in a 6-week Induction Program. The program helps participants to build a strong foundation for long-term recovery, develop life skills and prepare to re-connect with their community.

During the Induction program participants focus on topics such as:

- Stages-of-Change
- Cycle-of-Addiction
- Goal Setting
- Social Skills – Communication, Conflict Resolution
- Self Identity
- Relapse Prevention
- Understanding – Depression, Anxiety, Shame, Anger
- Cognitive Behavioural Therapy (CBT)
- Smoking Cessation

While some participants leave after completing the 6 week Induction Program, others may need more time, education, training and practical experience.

ONE80TC's long-term program provides additional learning opportunities through individual self-paced programs: 12-step, group and team activities and by applying those skills acquired during the Induction Program. Further support is provided through one-on-one mentoring, counselling with our psychologists and the support of other trained staff.

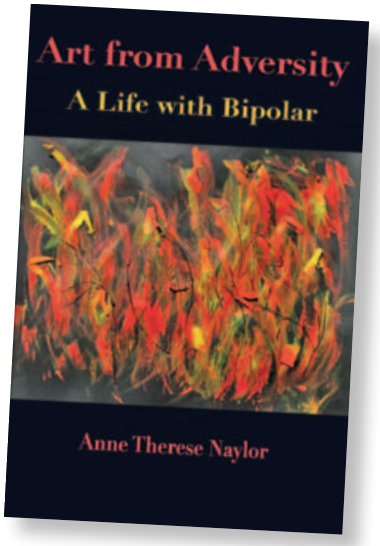
The next phase of the program is based on the participants' long-term goals around self-identity, family and relationships, personal development and employment. Completion of the long-term program is based on each individual working through their goal based contracts. This takes on average 9–12 months.

ONE80TC is a Christian-based organisation located in the Blue Mountains. The Program has helped thousands of young men take back control and get on with their lives. Participants can enter the ONE80TC program voluntarily or by referral. For more information visit: www.one80tc.org or Freecall: 1800 679 657

Learning from lived experience

THE ENVIRONMENT in which mental health services are delivered is rapidly changing. It is essential to establish better ways of working together and remaining connected what is at the core of all we do, people—with individual needs, expertise and the right to decide the direction of their recovery journey.

In this edition of VFP we are reviewing two books for consumers, carers and families, written from the consumer perspective. They are warts-and-all guides on what it's actually like to live with mental health issues and navigate the system that is designed to help.



Art from Adversity: A Life with Bipolar is one person's journey from devastating loss to a place of acceptance and strength – where a diagnosis is not the end but the beginning of a very different life. Anne Therese Naylor is a teacher, writer, painter, wife and mother of four. She also happens to have bipolar disorder.

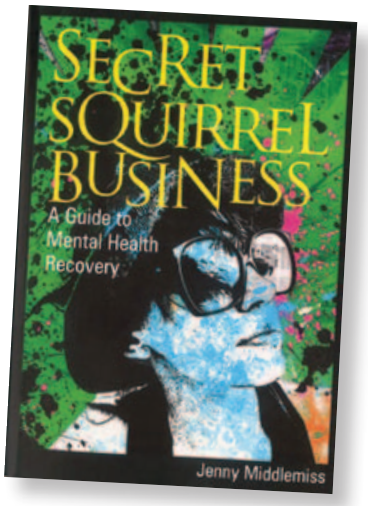
When unable to continue her work as an educator, Naylor returned to school herself to study visual arts. Making paintings and drawings, and getting the occasional tattoo, helped her to express herself and find a path forward. The book is filled with images of Anne Naylor's unique experience of a life fully lived with bipolar.

The book is divided into two distinct parts. Part one is a memoir composed of vignettes which swing from jagged and confronting to the humorous and saucy. A raw mix of prose, poetry and beautiful paintings map periods of mania and profound depression, loss of hope and a returning sense of self.

Part two is a guide to finding and accessing services, particularly those with a focus on bipolar disorder. It also highlights the particular challenges faced by carers and family.

For more information about Naylor's artwork, her story and her regular blog on living with bipolar visit: www.atnaylor.com/

Art from Adversity – A Life with Bipolar by Anne Therese Naylor (Glass House Books 2013)



Secret Squirrel Business – A Guide to Mental Health Recovery puts many aspects of the mental health service system under the microscope—from first experiences of hospitalisation, to exploring treatment options, through stigma and discrimination, to the added challenges of life with a dual diagnosis.

Chapters are punctuated by personal stories from across a range of ages and experiences. The book pulls no punches when addressing the fear, isolation and grief that accompanies a life changed by mental ill health, but it does so without losing sight of hopefulness and the possibility of recovery.

While many of the personal stories identify the gaps and shortcomings of the services currently available, particularly in the case of young people, there are uplifting stories too. Mental health and human services sector workers will find a wealth of knowledge to help inform and improve the services they provide.

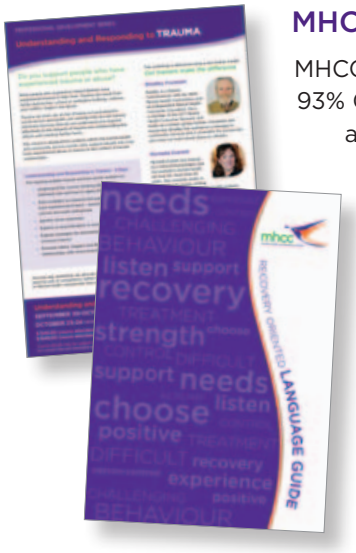
Readers are guided through activities and reflective practices that help to identify thought patterns at times of good health and in illness. Scattered throughout are tools, strategies and 'notes for the fridge door' that put the emphasis back on self-directed care and empowerment: "I am an expert in my own recovery"

Secret Squirrel Business – A Guide to Mental Health Recovery by Jenny Middlemiss (Ruah Community Services 2012) www.secretsquirrelbusiness.com.au/contact/

Did you miss our last issue? View From the Peak is available online at www.mhcc.org.au

2013 MEMBERS SURVEY

IN MAY and June this year MHCC conducted our annual Members Survey. We'd like to say a big thank you to our members who gave their time to respond. We really value your feedback. Congratulations also to Beate from Aftercare PHAMS at Taren Point who is this year's lucky draw winner of 10 double movie passes.



MHCC's performance

MHCC's overall performance received 93% Good – Excellent rating. Among the activities surveyed, 'Member Services' received the highest number of Good – Excellent ratings at 72% with 'Keeping members informed' and 'FYI weekly newsletter' getting an A+ from respondents.

MHCC projects

Members rated 'NSW Mental Health Rights Manual' and 'Mental Illness & Physical Health Issues' as the most useful projects, followed closely by the 'Recovery Oriented Language Guide'.

What our members want

Respondents also highlighted areas that they would like MHCC to do more work in:

- Readiness for DisabilityCare
- Alignment of the multiple mental health tools and standards, and
- Increased advocacy for consumer and peer led services.

Learning & Development

Of the qualification courses offered, 'Certificate IV Mental Health Work' received the highest number of responses indicating intent to enrol in the course within the next 12 months. This is great news for the sector which will benefit from the growing skills base of workers in frontline roles.

Of the Professional Development workshops conducted, members rated 'Understanding & Responding to Trauma' as the most useful, followed by 'Mindfulness in the Workplace' and 'Trauma Informed Approaches to Aboriginal Wellbeing'.

Keep checking mhcc.org.au for updates in workforce development and training for 2014.

From grants to tenders – references (from page 3)

1. Productivity Commission, 2010, *Contribution of the Not-for-Profit Sector*, Research Report, Canberra
2. ICAC, 2012, *Funding NGO Delivery of Human Services in NSW: A Period of Transition*, Position Paper, Sydney
3. NSW Department of Health, 2010, *NSW Health NGO Program Review Recommendations Report*, Sydney
4. The Grants Management Improvement Taskforce Report, MoH, 2012
5. Partnerships for Health, MoH, 2013

MHCC STAFF AND CONTACT DETAILS

Mental Health Coordinating Council is the peak body for community managed organisations working for mental health in New South Wales.

Ground Floor, Building 125
Corner Church and Glover Sts,
Lilyfield 2040
PO Box 668 Rozelle NSW 2039
Telephone: 02 9555 8388
Fax: 02 9810 8145
www.mhcc.org.au
email: info@mhcc.org.au

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mental health coordinating council

Position	Name	Email
Chief Executive Officer	Jenna Bateman	jenna@mhcc.org.au
Senior Policy Officer	Corinne Henderson	corinne@mhcc.org.au
Operations and HR Manager	Erika Hewitt	erika@mhcc.org.au
Senior Policy Officer Workforce Development	Tina Smith	tina@mhcc.org.au
Policy and Partnerships Officer	Stephanie Maraz	stephanie@mhcc.org.au
Policy and Research Officer	Tully Rosen	tully@mhcc.org.au
Project Officer Research Network	Deb Tipper	deb@mhcc.org.au
Policy Assistant	Lucy Corrigan	lucy@mhcc.org.au
Compliance and Quality Coordinator	Sheena Lee	sheena@mhcc.org.au
Community Engagement Officer	Carrie Stone	carrie@mhcc.org.au
Promotions Officer	Lenny Pelling	lenny@mhcc.org.au
IT Officer	Ian Bond	ian@mhcc.org.au
Finance Officer	Jill Dimond	jill@mhcc.org.au
Reception and Office Admin	Colleen Mosch	info@mhcc.org.au
Learning & Development		
Manager LD	Simone Montgomery	simone@mhcc.org.au
Training Services Team Leader	Jacqui Moreno Ovidi	jacqui@mhcc.org.au
Project Liaison and Development Team Leader	Chris Keyes	chris.keyes@mhcc.org.au
Training Support Officer	Lisa Van Praag	lisa@mhcc.org.au
Senior Admin Officer	Joanne Timbs	training@mhcc.org.au
Student Support and Admin Officer	Christine Kam	chris@mhcc.org.au
Student Support and Admin Officer	Nicole Cother	nicole@mhc.org.au
Partnerships Admin Officer	Rainbow Yuen	rainbow@mhcc.org.au
Admin Assistant	Melinda Shipp	training@mhcc.org.au
Admin Assistant	Rainbow Yuen	training@mhcc.org.au
Aboriginal Project Admin Officer	Liesl Homes	aboriginalprojects@mhcc.org.au
Online Learning Officer	Kat Fardian	kat@mhcc.org.au
Short Course Coordinator	Lorna Downes	lorna@mhcc.org.au