View from the peak

A quarterly publication from the Mental Health Coordinating Council Autumn 2013

Innovation comes from the west

MORE fanfare needs to be made of the great leap forward in mental health service delivery that has just been made in the western NSW towns of Broken Hill and Dubbo. Funds handed down by the Commonwealth for sub-acute care have been applied to implement a service model that focuses on preventing hospital admissions and improving community connection by joining public and community sector expertise to fill a service gap that has been longstanding in NSW.

Whilst NSW has had a range of options for people transitioning out of acute care, there has been a lack of focus on giving people a place to go when they and their family realise they are becoming unwell. What makes the new Dubbo and Broken Hill units unique in NSW is that whilst they do support people transitioning out of acute care they are also focused on providing a place for people to go before they become so unwell hospital admission is the only option.

By combining community sector and public sector expertise in the design and management of the units along with high levels of consumer and carer participation the units are likely to yield substantial learning across the board on how people with mental health conditions can be supported to stay well in the community when a modern purpose built, comfortable, respectful and welcoming, 'step-up' option is available.

The community sector organisation who is managing both units is Neami. Neami has experience running somewhat similar units in Victoria known as Prevention and Recovery Care (PARC) and has a solid reputation for delivering quality recovery oriented services in outreach and assertive outreach (including homelessness) in NSW.

Wiradjuri artist Lewis Burns opens the Dubbo unit with a traditional smoking ceremony

Innovations like these two units have their time when the right people are in the right chairs at the right time and this is very true of this initiative. With Minister for Mental Health Kevin Humphries supporting introduction of new models that can really make a difference, and forward thinking senior people in both the Mental Health Drug and Alcohol Office and the Western and Far Western NSW Local Health District Mental Health Services, true collaboration with community sector approaches and perspectives has been possible.

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Susan Daly, Director Mental Health and Drug & Alcohol – Far West LHD and the staff at the new Dubbo unit

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Russell Roberts, Area Director Mental Health & AOD – Western LHD, at the Dubbo unit opening

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Over the coming months MHCC will be providing updates on how the units are progressing, focusing on particular aspects such as consumer and carer outcomes including for Aboriginal people and those in remote locations, workforce configuration and collaboration across sectors and how social and community connections are maintained and developed for the people using the service.

Congratulations to all involved and particularly to the Neami Board, CEO and staff who along with their public sector counterparts are leaders at this important watershed moment in reframing how cross sector collaboration can improve the lives of people with mental health conditions.

Best wishes

Jenna Bateman
Chief Executive Officer

Partners in Recovery update

SUCCESSFUL tenders for stage one of the $550 million Partners in Recovery program have been announced.

This National program is targeted at better coordination between services such as medical care, housing, income support, employment, education and rehabilitation services that support people with mental health and complex needs.

49 of the 61 Medicare Local regions were successful in the first round of applications to rollout the PIR program. The Department of Health and Ageing will work with the 12 remaining regions to ensure their readiness over the coming months.

Lead agency status for PIR tenders was determined by consensus view of the consortia members participating in Medicare Local regional bids. The table below illustrates the numbers and the successful community organisations state by state.

State	No. of ML regions	Number of successful bids	Lead Agency – Medicare Local	Lead Agency – CMO
ACT	1	1	1	
NT	1	1	1	
NSW	17	16	11	Schizophrenia Fellowship Richmond PRA Community Care Northern Beaches New Horizons Mission Australia
QLD	11	10	7	Aftercare Centacare Lifeline
SA	5	4	4	
TAS	1	1		Anglicare
VIC	17	10	10	
WA	8	6	5	Richmond Fellowship WA

NCAT – Oversight of the Super Tribunal

ON 26 October 2012 the Attorney General announced the establishment of the NSW Civil and Administrative Tribunal (NCAT). More than 20 of NSW's existing tribunals will be integrated into NCAT, providing a single entry to most tribunal services for the people of NSW. The Mental Health Review Tribunal is not included in this process.

Most tribunals were opposed to the amalgamation. However the NSW Government decided that 'the benefits of an integrated tribunal system include the opportunity to identify and roll out best practice in a range of areas including learning and development, alternative dispute resolution, and electronic service delivery.' MHCC hopes that this integrated model will not result in a loss of expertise as has been experienced in other jurisdictions. Many tribunals such as the CTTT have a statutory obligation to assist the public, and therefore need to have expertise in the area in which they are operating registry services.

"An obvious question is whether or not an amalgamated tribunal model is more effective than a series of smaller, specialised tribunals in delivering administrative justice, in other words, whether there is any net gain to be had from a government's decision to amalgamate" (Bacon, 2006) .

Justice Murray Kellam spoke about concerns around the potential for political interference leading up to the creation of Victorian Civil and Administrative Tribunal (VCAT) when he wrote: "it was not uncommon for there to be a perception of political interference with tribunals by the appointment of members who were known by the government of the day to have a viewpoint of a particular type." MHCC expressed their views in a submission to the inquiry into the consolidation in 2011.

Due to be phased in from 1 January 2014, NCAT will be responsible for handling a huge range of disputes and applications including: Civil and Commercial Disputes: e.g. between consumers, victims, tenants and landlords. Human rights matters: e.g. equal opportunity, discrimination, victims support and guardianship. Administrative law (the citizen and the Government): e.g. licensing and regulatory disputes, occupational and professional discipline, and access to Government information.

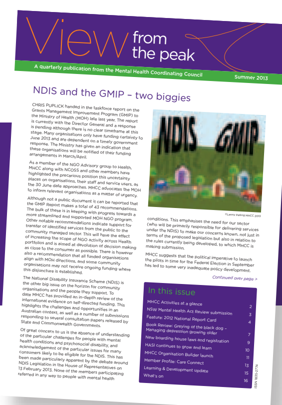
It is proposed that NCAT will have a divisional structure that preserves the specialised jurisdiction and expertise of the 20 member tribunals. The current Bill identifies the divisions as: Administrative and Equal Opportunity Division; Consumer and Commercial Division; Occupational and Regulatory Division; Guardianship Division and Victims Support Division.

More than 20 of NSW's existing tribunals will be integrated into NCAT, providing a single entry to most tribunal services for the people of NSW.

A Steering Committee has been established to maintain strategic oversight of the project and to make decisions about the institutional design of NCAT and the appropriate allocation of resources. A Reference Group of key stakeholders has been established to provide input on behalf of the affected tribunals, tribunal users and relevant peak bodies. They will be consulted on legislation and other issues arising during the project and play an important role in engaging with the broader stakeholder group and providing feedback and information to the Steering Committee and project team. The Reference Group is chaired by Linda Pearson, Commissioner of the Land and Environment Court of NSW and member of the Administrative Review Council (ARC). NSW Council for Intellectual Disability, MHCC and the Brain Injury Association of NSW has a joint representative on the reference group. There is also a representative of People with Disability Australia.

For further information contact Corinne Henderson at corinne@mhcc.org.au and keep up-to-date with developments in relation to NCAT at www.tribunals.lawlink.nsw.gov.au

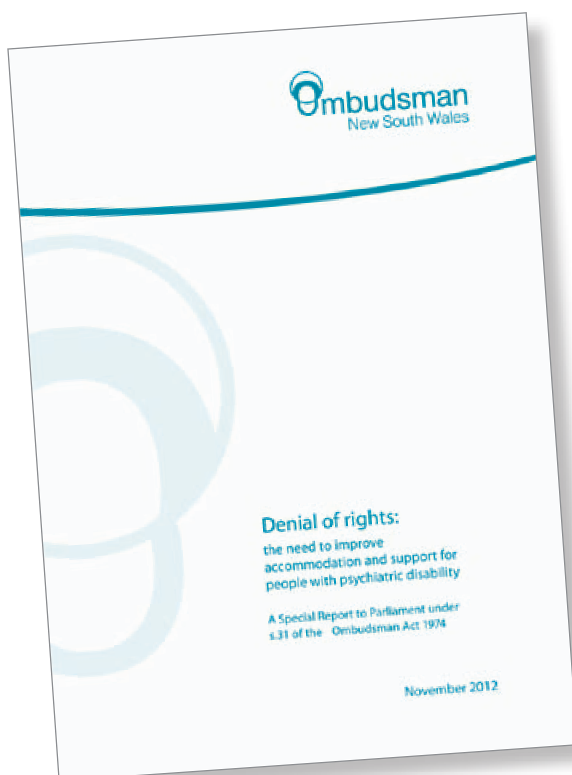
Did you miss our last issue? View From the Peak is available online at www.mhcc.org.au



Denial of rights: the need to improve accommodation and support for people with psychosocial disability

IN NOVEMBER 2012, the NSW Ombudsman published a paper entitled ‘Denial of rights: the need to improve accommodation and support for people with psychosocial disability’, a special report to Parliament under s.31 of the *Ombudsman Act 1974*. In the report the Ombudsman reports on people living in mental health facilities who in their judgement (in consultation with two expert consultant psychiatrists) no longer need to be involuntarily detained, and the multiple barriers that prevent them for exiting.

In the report the Ombudsman writes that “the consequences of the situation are significant – for individuals themselves, and for the mental health system as a whole. Many people are being denied fundamental rights under mental health and disability legislation, including the right to live in the community and to receive support in the least restrictive environment possible.” This comment highlights an issue frequently raised by MHCC concerning the need for cross agency collaboration and the development of service and care coordination skills across disciplines and sectors to support consumers in the community.



Not only are those detained in mental health facilities at a disadvantage, but those needing acute care may be unable to access the care they need leading to poorer long-term outcomes for them and their carers. The report is evidence that ADHC and NSW Health must work together to support this group of vulnerable consumers and with the NDIS on the horizon this presents an opportunity to improve practice across disability and mental health service sectors.

Briefly, the project reviewed the files of 95 people in 11 mental health facilities. The Ombudsman consulted with almost 300 stakeholders and discussed the draft report with agencies, relevant Ministers and the NSW Mental Health Commissioner. The report was tabled in Parliament in November 2012.

The investigation provided material, including most alarmingly that over half those studied had been admitted for 2–10 years. The majority (73) were involuntary patients. Thirteen people had been in hospital over 20 years. A small number that had been there as a teenager who now would have to be discharged to aged care. The greatest number had schizophrenia or schizoaffective disorder and other conditions and over 60% had a cognitive impairment. The age range was 24–82 years (average age 49 years). The vast majority had prior admissions; almost half had 10 or more previous admissions and over one-third were in secure or medium secure units; 17 people were in acute units.

Despite the lengthy incarcerations, almost a third had no current challenging behaviours and one-third had been granted unescorted leave. However, less than half had accessed rehabilitation activities. The files demonstrated that the views of 80 patients were known – two-thirds (54) said they wanted to be discharged. But of the 55 people whose families’ views were known, most (34) wanted them to stay.

The expert psychiatric advice reported that most (82) may be clinically well enough to be discharged from hospital although all require ongoing support since all had a disability (all

Many people are being denied fundamental rights under mental health and disability legislation.

but two permanent), and all had impairment in one or more domains affecting daily living. They concluded that most had severe, persistent and complex needs requiring a high level of support, including ongoing disability support. However, the support needs of 18 people were not particularly complex.

Of the 82 people considered clinically well enough to be discharged there was no evidence of any discharge planning (DP) for one-third (26). The amount of DP was highly variable, with no significant association with the complexity of person's support needs, involvement in work/rehab activities, or views of family members. Significantly more discharge planning had occurred where a person had been granted unescorted leave and/or said they wanted to leave.

Clearly identified was that mental health staff were inconsistently applying the discharge planning policy, and the basis on which decisions were made was unclear because recent assessments were not always evident. The preparation of reports for Mental Health Review Tribunal (MHRT) hearings did not prompt mental health staff to review discharge or undertake assessment to determine readiness for discharge. It was also unclear how staff viewed the need for 24/7 support.

Clearly evident was the different levels of knowledge of available accommodation and community support options, and eligibility criteria. However whilst reasons for declining options were not always clear, the wishes of patients had affected discharge planning for a number of reasons including: not wanting to leave; only prepared to live in one location; would not accept the proposed accommodation and support options.

Disturbingly there was a difference in the quality of information in the reports provided to the MHRT and a lack of clarity about what had informed the reports, particularly views on the need for 24/7 support. It seemed that MHRT hearings did not consistently prompt mental health staff to conduct an assessment of the person to inform their opinion about readiness for discharge, and the Ombudsman found that reports were largely unchanged over a number of years, including reference to the same incidents (of, for example, non-compliance, challenging behaviours) repeatedly.

The report concluded that there is an adequacy of information provided to the MHRT to inform its decisions. In some cases, information given to the MHRT said that the individuals could not be discharged as no less restrictive accommodation was available in the community to meet their needs. However, they found instances where staff or individuals refused to accept offers of less restrictive options; and no/minimal discharge planning was undertaken to establish whether appropriate options were available.

The expert psychiatric advice reported that [82 people] may be clinically well enough to be discharged from hospital although all require ongoing support.

Other barriers to transfer out of the system were problems with inter-LHD transfers and concerns about the availability and adequacy of community mental health support as well as access to accommodation and support under the *Disability Services Act 1993*. Eligibility depends heavily on diagnosis rather than functional impairments or disability and there were infrequent referrals by mental health staff with a strong focus on ADHC services.

It is no news to the mental health sector that there are insufficient long-term and high support needs housing places available and that mental health patients are ineligible for accommodation in the disability sector. Current provision in the mental health sector is insufficient to meet existing demand, let alone provide for people in mental health facilities who could be discharged. Additionally distribution and availability is inequitable across NSW

Critical to solving this problem is a need for a more flexible range of accommodation and support options using recovery orientated, person-centred and individualised funding approaches and a strong commitment to interagency work between NSW Health and ADHC via a MOU.

The Ombudsman has made 12 recommendations – directed to FACS, ADHC and NSW Health. A response was due in March 2013, but at writing this article has been delayed and a progress report due by 31 December 2013.

MHCC congratulate the NSW Ombudsman on this important piece of work and have referred to it in several of their submissions to government including their submission to the review of the NSW Mental Health Act 2007 available at: www.mhcc.org.au/documents/Submissions/Sub-Issues-under-NSWMHAct07.pdf

The Ombudsman's Report is available at http://bit.ly/ZMhrFs

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Language matters... MHCC Recovery Oriented Language Guide

"Words are important. The language we use and the stories we tell have great significance to all involved. They carry a sense of hope and possibility or can be associated with a sense of pessimism and low expectations, both of which can influence personal outcomes".[1]

THE Mental Health Coordinating Council (MHCC) has developed a Recovery Oriented Language Guide because language matters in mental health. We must use words that convey hope and optimism and that support, and promote a culture that supports, recovery.[2]

The Language Guide includes:

- general guidelines and principles for use of recovery oriented language
- specific examples of language promoting acceptance, hope, respect and uniqueness versus 'worn out words'
- guidance on preferred language when talking about suicide, and
- specific guidelines for use of language when speaking or writing about a person experiencing a mental health problem/ emotional distress or psychosocial disability.

We know that people with psychosocial disabilities are amongst some of the most marginalised in the Australian community and many live with poverty, discrimination and social isolation as a normal part of their lives.[3] The words that we use when speaking with people are a critical tool to ensure that we are all able to engage with and effectively respond to issues of prejudice, stigma and discrimination, which can erode human rights and result in disadvantage and social exclusion.

The terms psychosocial and psychiatric disability are often used interchangeably. Psychosocial disability is now the preferred term and it is used by the United Nations Convention on the Rights of People with Disabilities as it acknowledges the often devastating impacts on, for example, housing, employment and relationships that people affected by mental illness/distress can experience.[4]

Development of the Language Guide has been informed by a number of sources including: current literature on recovery orientated practice; conversations with people working in the mental health sector; and, most importantly, the voices of people with lived experience of mental illness and recovery.

The Language Guide underpins MHCC's Organisation Builder (MOB) Policy Resource and organisations providing recovery oriented and trauma-informed services to people affected by mental/emotional distress are encouraged to also adopt it.

The MOB Policy Resource makes available more than 200 policies, procedures and other supporting documents to help improve the quality and effectiveness of recovery oriented service delivery, including a template for this Language Guide that might be adopted for use within your organisation. The Language Guide template is available as a complement to the 'Valued Status Policy' in the 'Prevention and Promotion' category of the MOB Policy Resource.

The MOB Policy Resource can be accessed at the MHCC website: mob.mhcc.org.au.

Extract from MOB Policy Resource:

DO	DON'T
DO put people first: **DO** say "person with mental illness". **DO** say "a person diagnosed with...".	**DON'T** label people: **DON'T** say "he/she is mentally ill". **DON'T** define the person by their struggle or distress. **DON'T** equate the person's identity with a diagnosis. Very often there is no need to mention a diagnosis at all. It is sometimes helpful to use the term "a person diagnosed with", because it shifts the responsibility for the diagnosis to the person making it, leaving the individual the freedom to accept it or not.

1 Devon Partnership Trust and Torbay Care Trust (2008). Putting Recovery at the Heart of All We Do.

2 Department of Health and Ageing (2012, draft). *National Recovery Oriented Mental Health Practice Framework.*

3 National Mental Health Consumer & Carer Forum (2011). *Unravelling Psychosocial Disability: A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions.*

4 United Nations General Assembly (2006). *Convention on the Rights of Persons with Disabilities.*

CMHDARN: relationship development with university staff

THE CMHDARN project is a collaborative project seeking to enhance research skills and understanding across the community managed drug and alcohol and mental health sectors, with the longer term objective being to enhance capacity and increase the level of engagement by community managed organisations in research activity. As discussed in past issues of *View from the Peak*, the CMHDARN activities focus on many different aspects of capacity building.

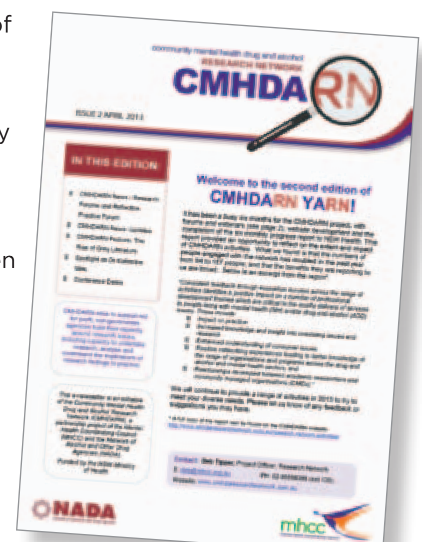
These include:

- Research Seeding Grants
- Research Forums
- Reflective Practice forums
- CMHDARN Website
- Mentoring
- CMHDARN – Yarn, an e-newsletter

A consistent thread through these activities is an aim to develop and enhance relationships between staff of community managed organisations and academic research staff of universities.

A consistent thread through these activities is an aim to develop and enhance relationships between staff of community managed organisations (CMOs) and academic research staff of universities, which in turn increases shared understanding about issues, processes and strengths. It is hoped through these improved relationships better skills exchange will be facilitated and there will be an increase in collaborative research work. To that end, an examination of the people from universities engaged in CMHDARN activities paints an interesting picture. In the last two years (2011–2013) the active involvement of people from universities has been broad. The nature of this involvement includes:

- **Presentations to, and workshop facilitation of, CMHDARN research forums and workshops** (12 presenters from 5 universities). The feedback in relation to these presenters has been extremely positive, with participants indicating the contribution of academic researchers has added to their enhanced understanding of the particular issues.
- **Attendance at CMHDARN organised events** (around twenty from eight universities): this provides opportunities for networking between the CMO sector and university staff, supporting relationship building.
- **Membership of CMHDARN project reference group**: with its recent expansion, there are now four members from four universities supporting this group. This provides opportunities for CMHDARN to draw on the broad experiential base of different disciplines, foci and university centres of excellence to support the professional development of CMHDARN members in the drug and alcohol and mental health community managed sectors.
- **CMHDARN Research Seeding Grants:** each of the sixteen recipient CMOs is required to develop a relationship with an academic research partner. These relationships lead to increased understanding, skills and knowledge exchange between those involved, and the creation of the potential for additional future partnerships.



Reflections of several university staff who have been involved in CMDHARN activities to date has been to note how critical the shared relationship between them and CMO staff is and to encourage workers to view it as an equal relationship for knowledge, experience and skill exchanges. It is through these relationships and enhanced insights that the research undertaken by university staff in collaboration with CMO staff will ultimately have more relevance to practice and lead to higher quality outcomes for consumers.

NDIS: Opportunities presenting for Hunter area could lead the way in coordinated health and social care

PLANNING for the NSW launch of the National Disability Insurance Scheme (NDIS – to be known as DisabilityCare Australia) in the Hunter is accelerating and MHCC has been working closely with a variety of organisations, including the NSW Mental Health Commission, to better understand how mental health will be situated in the NDIS. Mental health (i.e., psychosocial/ psychiatric disability) will be included in NDIS. Commonwealth funded mental health programs (e.g., Personal Helpers and Mentors, Day to Day Living, Mental Health Respite) will in the future be accessed through the NDIS. It is notable that these programs are non-residential and NSW Health has advised that some Housing and Accommodation Support Initiative residential places may also be in scope for NDIS.

The Launch Transition Agency has established their Hunter region office, begun recruiting staff and informed us that the NSW roll-out will target:

- 3000 people in the Newcastle LGA in year 1 – 2013–14
- 2000 people in the Lake Macquarie LGA in year 2 – 2014–15
- 5000 people in the Maitland LGA 2in year 3 – 2015–16

In 2017/18 and 2018/19, the NDIS will increase to 130,000 people across NSW. The NSW Department of Ageing Disability and Homecare (ADHC) will make a staged withdrawal from its role as a funder of disability services between 2015/2018. From 1 July 2013 people with disabilities receiving ADHC funded services will be supported to answer the question: "Who would you like to be providing services to you"? In the Hunter, this support will be provided through the new Saint Vincent de Paul 'Ability Links' program.

There are currently 2600 ADHC clients receiving community based services in the Newcastle LGA and many of these are people with mental health issues, either as a primary or secondary diagnosis.

The Hunter region is unique in that is has several large ADHC funded 'residential centers'/ institutions (i.e., Stockton in the Newcastle LGA, Kanangra in the Lake Macquarie LGA, and Tomaree in the Port Stephens LGA). All of these are scheduled for 'redevelopment' over the next few years and the NDIS provides opportunity for this to occur. Kanangra is collocated with Morisset Hospital, a NSW Health non-acute psychiatric hospital, and we note the recent NSW Ombudsman report in which it was identified that around 6 people residing there would be more appropriately placed in the community.[1] This number increases to 95 for people across NSW and many of these have coexisting intellectual disability/impairments.

Positive progress for the inclusion of mental health in the NDIS has been made and other opportunities and possibilities are presenting, as described above. However, a range of issues continue to lack clarity and MHCC will continue in our advocacy to resolve them. Recent COAG Guidelines regarding the interface of the NDIS with other health and community service systems may assist in this and on-the-ground local action will also be needed.

UNRESOLVED ISSUES FOR NDIS AND MENTAL HEALTH

- What are the activities being undertaken to prepare community managed mental health services in NSW not currently in receipt of ADHC funding for NDIS transition?
- What are our plans for closing the large gap between the 230,000 people currently on the Disability Support Pension (DSP) due to psychosocial disability across Australia and the 57,000 people that have been agreed will be transitioned to the?
- Why is it that 'early intervention' under the NDIS will seemingly not apply to people with psychosocial disability (this is counter to recovery oriented service provision and known evidence based practice)?
- What will be the required interface between the NDIS and health, especially as this relates to people's acute mental health treatment needs and also the physical healthcare needs of people living with mental illness?
- How will the NDIS be similar to/different from, and how will it work with, the new commonwealth Partners in Recovery program that is also in scope for NDIS (lead agency for this in the Hunter will be the Hunter Medicare Local).

1 NSW Ombudsman (2012). *Denial of Rights: The need to improve accommodation and support for people with psychiatric disability.*

Excerpt from 'Principles to Determine the Responsibilities of the NDIS and Other Service Systems' (COAG, 19 April 2013)

Mental Health

1. The health system will be responsible for:
   a. supports related to mental health that are clinical in nature, including acute, ambulatory, continuing care, rehabilitation/recovery and early intervention, including clinical support for child and adolescent developmental needs; and
   b. any residential care where the primary purpose is for inpatient treatment or clinical rehabilitation, where the service model primarily employs clinical staff.
2. The health and community services system will be responsible for supports relating to a co-morbidity with a psychiatric condition where the co-morbidity is clearly the responsibility of that system (e.g. treatment for a drug and/or alcohol issue).
3. The NDIS will be responsible for non-clinical supports that focus on a person's functional ability, including those that enable people with mental illness or a psychiatric condition to undertake activities of daily living and participate in the community and in social and economic life.

MHPN: supporting inter-professional networks

MHCC CONTINUES to work with the Mental Health Professionals Network (MHPN) to support inter-professional mental health networks across Australia. Network members include: consumer/carer advocates, peer workers; general practitioners; psychiatrists; psychologists; mental health nurses; occupational therapists; social workers; allied health professionals; community workers involved in primary mental healthcare.

MHPN has established 450 interdisciplinary community mental health networks across Australia, of which approximately 40% are located in regional, rural and remote locations. MHPN provide the finance for locally driven networks across Australia which aims to improve consumer outcomes by promoting collaborative practice and peer support amongst professionals and service providers providing care and support to people with mental health conditions. Network members meet regularly to participate in education, clinical review, peer support, community development, collaboration and networking opportunities. Each network is coordinated by a network member with support from MHPN project officers. Local meetings are usually held every two or three months and are accepted as professional development by the APS and the counselling and psychotherapy associations.

MHCC encourage members to join their local network. Members can also go to any meeting they like and for example in the Sydney's Inner West there are at least eight networks to choose from. MHCC attended several meetings in the area over the last year which included presentations on the impact of interpersonal trauma, working with people with PTSD, symptoms and health outcomes for people with an eating disorder, sexual dysfunction, gambling problems and using writing as a therapeutic strategy.

By becoming a member of an MHPN network, you can:

- expand mental health referral networks
- broaden knowledge of local service providers
- enhance professional development opportunities
- share skills and expertise.

Online professional development

MHPN provides a range of online learning and networking opportunities for people working in primary mental health care. This includes a series of regular, free webinars with panels of professionals participating in a facilitated client scenario discussion. The objective of the webinars is to demonstrate and encourage a collaborative approach to care and support of people with mental health problems.

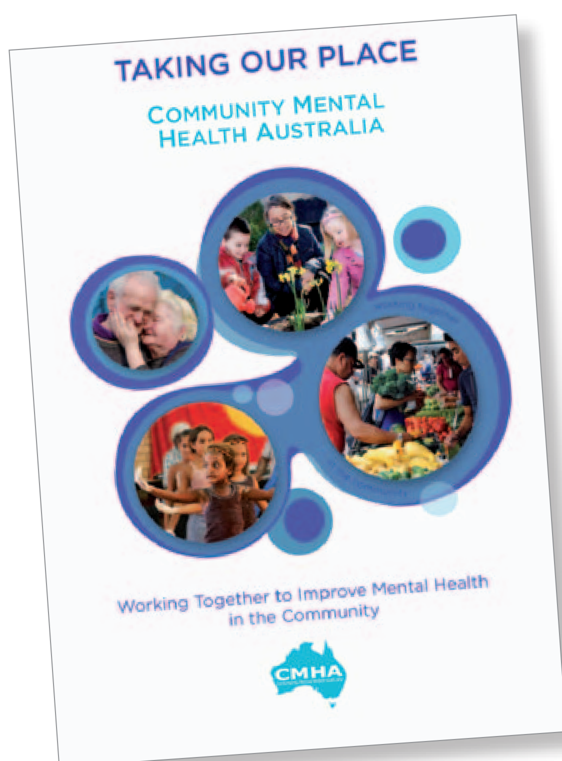
MHPN Online Webinar recordings are available for download to MHPN members at www.mhpn.org.au

Reflections on the professionalism and expertise of the community sector mental health workforce in a rapidly changing landscape

MHCC's Strategic Directions 2012/15 plan has a continuing priority to develop our workforce. The vision for this activity is that people with mental health conditions are supported by skilled and caring community workers. The outcome sought is that the community managed mental health sector is included in state and national workforce development strategies and plans.

Planning for the implementation of both the National Disability Insurance Scheme (NDIS) and Partners in Recovery (PIR) has flagged continuing poor knowledge about community sector mental health services, the workforce that deliver them, their qualifications/experience and the emerging career development pathways that support the workforce.

MHCC last undertook a strategic state wide workforce development needs analysis for our sector seven years ago and much has changed in that time. In 2005/06, the sector was estimated to be around 1,500/2,000 FTE and the sector has at least doubled since then (i.e., funding enhancements from NSW Health and through the COAG National Action Plan for Mental Health 2006/11). We anticipate continuing rapid growth of the sector over the next five years (i.e., enhancements to existing state and commonwealth funded programs and the introduction of new programs, such as PIR, as the skills and contributions of community sector mental health services continue to be more appropriately valued).



Community sector mental health workers are primarily a workforce that delivers psychosocial rehabilitation and recovery support services.

We know that as the sector has grown that it has also continued to develop expertise and a clearer sense of its' professional identify. For NSW, this has been achieved in a large part due to the support to the sector offered through MHCC's RTO/Learning and Development. Since becoming an RTO in 2008, MHCC has trained more than 5,000 people and also successfully implemented a wide range of other structured workforce development and learning activities.

The findings of the National Mental Health NGO Workforce Study confirmed the qualifications and experience of community sector mental health workers (see side box). While the Landscape Survey of the NGO Workforce Study struggled to categorise the diversity of services being provided these are now strongly articulated in the 2012 Community Mental Health Australia (CMHA) *'Taking Our Place'* publication and this was informed by MHCC's 2010 NSW Sector Mapping Project.1 This learning is now informing directions for a planned service taxonomy and national minimum data set collection for community mental health services through the Australia Institute of Health and Welfare.

Community sector mental health workers are primarily a workforce that delivers psychosocial rehabilitation and recovery support services (i.e., health and wellbeing recovery support services).

1 Community Mental Health Australia (2012). *Taking Our Place – Community Mental Health Australia: Working Together to Improve Mental Health in the Community*. Sydney: MHCC.

Emerging facts about community sector mental health services and the workforce that deliver them are making it increasingly risky and erroneous to perceive the sector through the lens of 'assistants and support workers'.

MENTAL HEALTH WORKFORCE DATA

The 2011 National Mental Health NGO Workforce Scoping Study confirmed the size of the sector to be about 800 organisations and its workforce was estimated to range between 15,000 to 26,000 employees (CMHA conservatively estimate this to be about 12,000 FTE).[1] By way of comparison, the public mental health service direct care FTE is about 21,000.[2] 42 % of responding organisations have been delivering services for more than 20 years. 43% of workers identified as having health qualifications — mostly in social work, psychology or nursing — and 34% of workers had a vocational qualification with the majority of these being at the Certificate IV and Diploma levels. State level data was unable to be extracted from this data collection.

1 National Health Workforce Planning and Research Collaboration (2011). *Mental Health Non-Government Organisation Workforce Project Final Report*. Adelaide: Health Workforce Australia.

2 Australian Institute of Health and Welfare (AIHW, 2010). *Mental Health Services in Australia 2007-08*. Mental Health Services no. 12. Cat. no. HSE 88. Canberra: AIHW.

In stating this, we acknowledge that a significant and growing number of community organisations are funded to provide other acute, sub-acute and talking therapy services. What makes our sector unique is that whatever the service type we are funded to provide – and regardless of the diverse qualifications and experience of the workforce that may deliver them and including those with lived experience of mental/emotional distress and recovery – the services delivered are more likely to be informed by the 'personal' view of recovery (i.e., holistic and whole of life recovery oriented service provision is more likely to occur).

Emerging facts about community sector mental health services and the workforce that deliver them are making it increasingly risky and erroneous to perceive the sector through the lens of 'assistants and support workers'. This devalues the many contributions that have been made by non-government private not-for-profit mental health services for more than 100 years in Australia. Considerable investments have been made in the sector by the Australian government over the last ten years to better fund and develop the sector, and this has included considerable work undertaken by the sector itself to develop its' workforce.

The Certificate IV in Mental Health or equivalent is seen as a voluntary minimum standard for work in the sector. Many university graduates working in the sector have voluntarily undertaken this or the higher level Diploma in Community Services Practice (Mental Health and/or Drug and Alcohol) to acquire the vocational skills required for recovery oriented service provision. A new Certificate IV in Mental Health Peer Work was endorsed in 2012 in acknowledgement that these are vocationally different from all other mental health work roles – whether university or vocationally qualified.

The mental health workforce continues to be poorly understood beyond the five key disciplines that have traditionally worked in public and private mental health settings: doctors, nurses, psychologists, social workers and occupational therapists.

A major strategic direction for MHCC as we move through 2013 will be to revisit the workforce development training needs analysis and to use this learning as a basis to continue our support to the sector in the area of workforce development and learning.

Congratulations to our 2013 graduates

THE 2013 MHCC Learning & Development Graduation was held at Aerial UTS Function Centre on 15 April. Over 230 students have completed their qualifications in 2013 across Certificate IV in Mental Health, Certificate IV in Training and Assessment, Diploma of Community Services (Mental Health and AOD/Mental Health) and the Advanced Diploma of Community Sector Management.

NSW Mental Health Commissioner, John Feneley, presented students with their awards to enthusiastic cheers from peers, friends and families. As part of the event the Commission also launched ASCA's National Guidelines for Treatment of Complex Trauma, Trauma Informed Care and Service Delivery, and MHCC's Trauma Informed Care training – *Understanding and Responding to Trauma* for Workers and Managers.

ASCA President Dr Cathy Kezelman addreesd the audience on the effects of childhood trauma on adult mental health and reflected on her own personal journey which has informed her strong advocacy in this area. The MHCC training products in Trauma Informed Care respond to a growing awareness of the prevalence of trauma among people who use mental health services. It is encouraging to see the next generation of community mental health and human services workers embracing the need to provide appropriate services in this challenging area. For details on TIC training visit http://bit.ly/11PdDkA

NSW Mental Health Commissioner, John Feneley

Learning & Development Manager, Simone Montgomery and MHCC Trainer and Consultant Gillian Bonser with the 2013 Advanced Diploma graduates

A PANEL of graduates rounded off this fantastic day by sharing their training experiences and their hopes for putting all they had learned into practice in the workplace:

"The Certificate IV in Mental Health has been extremely important for me as a Peer Support Worker because the course content covers most if not all situations I am likely to be exposed to in my work. The course is very hands on; very practical too, which means I can put into practice (with a short lead time) the things I have learned. This can only serve to make me a better, more focused worker.

[This course] has made a significant contribution in broadening my knowledge base and helped point the way forward to further studies – I will be commencing the Diploma in Mental Health in 2014".

Richard McInerney, graduate *(pictured)*

National directions for mental health workforce development

MHCC HAS a leadership role within the Community Mental Health Australia (CMHA) alliance in the area of workforce development. Some current activity in this area is described below.

Practice Standards/Mental Health Workforce Capabilities

A 'contained' review of the National Mental Health Practice Standards was completed in late 2012 and these are now in the process of being endorsed prior to public release, along with the National Recovery Oriented Practice Framework. The practice standards continue to focus on the five key disciplines that have traditionally worked in mental health: doctors, nurses, psychologists, occupational therapists and social workers. The review was undertaken to ensure that the 2002 practice standards align with the new 2010 National Mental Health Standards, and especially the new Recovery Standard and overarching Principles for Recovery Oriented Service Provision.

The practice standards review is now informing the development of a national mental health workforce capabilities framework. This activity is aligned to Health Workforce Australia's (HWA) new Mental Health Workforce Reform Program and also HWA's development of national health workforce competencies/capabilities. The mental health workforce capabilities framework is to be inclusive of public, private and community sector work settings, and a wider range of work roles including vocationally trained mental health workers and peer workers. MHCC is representing CMHA on the Technical Working Group developing the capabilities framework and is advocating for the centrality of consumer, carer and community experiences to be the main driver in their development.

Peer Workforce Development

MHCC is also representing CMHA on the HWA Mental Health Reform Program Project Advisory Group (PAG). In addition to looking at mental health workforce capabilities the PAG has oversight of two other projects. One is a Mental Health Peer Workforce project being undertaken with Dr Leanne Craze.

The first phase of this project runs through June 2013 and will work to validate the current peer workforce; and to analyse the current mental health peer workforce to identify its profile, what does and does not work, and barriers and enablers to employment. It will examine how the role and contribution of peer workers, those with a lived experience of mental illness, can be extended and how the capacity of the overall peer workforce can be grown. This project is being undertaken as a foundation to better understand future directions for peer workforce development and includes surveys and site visits being undertaken between March and May. Development of the peer workforce is vitally important for changing the culture and recovery orientation of mental health services that may still align with a medical model view of recovery with its focus on illness, symptoms and deficits.

The mental health workforce capabilities framework is to be inclusive of public, private and community sector work settings.

The third HWA project is about improved collections for mental health workforce data.

HWA have signed a Memorandum of Understanding with the NMHC to help guide their work together in the area of mental health workforce development. MHCC will continue to keep both our member agencies and CMHA affiliates informed about directions for national mental health workforce development through CMHA's Workforce Development Working Group.

SOME MUCH WELCOMED NEWS...

The National Mental Health Commission (NMHC) has funded CMHA through MHCC's registered training organisation (RTO/Learning and Development) to develop the learning and assessment materials required to deliver the newly endorsed Certificate IV in Mental Health Peer Work. MHCC will be working with the National Mental Health Consumer and Carer Forum to develop these materials during 2013.

Wesley Mission

WESLEY MISSION has been supporting vulnerable and marginalised people around Sydney for over 200 years. This includes offering programs and services for the homeless, people with mental health problems, frail/aged, disabled, the unemployed, and people affected by trauma.

Wesley Mission is working to build a trauma informed workforce so that they can offer people who seek their help the compassion, understanding and hope they need.

VFP How is Wesley Mission responding to service users that may have experienced trauma?

WM Wesley Mission Counselling Support Services (WCSS) engages clients with problem gambling, financial and legal issues. It is recognised that this client population may present with complex trauma in their lives and are often motivated to seek counselling only after reaching a crisis point. Clients may be re-traumatised as a result of this crisis.

Outwardly, client presentation can vary from a highly distressed state to an apparently calm. The presenting issue may mask any underlying trauma. It is important therefore for client contact workers in the organisation to assume that trauma may be present.

Whilst the majority of our counselling staff have previously trained to work with trauma, it was recognised that the organisation at large may not always be positively proactive in the management of trauma.

In 2011 Jeff Lucas, Operations (Manager for WMCSS) attended the MHCC Trauma Informed Care and Practice conference which included a presentation by Kathleen Guarino from The National Centre on Family Homelessness regarding the development of a trauma informed organisation.

Recognising the importance of this concept, Mr Lucas established a working committee in March 2012 to give impetus to the development of a trauma informed care practice (TICP), building on the Trauma Informed Organisational Toolkit as developed by the National Centre on Family Homelessness. Since then WMCSS has continued to build specific relationships with Adults Surviving Child Abuse (ASCA) and the MHCC in relation to trauma informed care.

VFP In light of the growing awareness of the prevalence of trauma, how is WM assessing the needs of people impacted by trauma and the organisation's capacity to assist them?

WM A working committee was established in March 2012 to give impetus to the development of a trauma informed care practice. To date, WMCSS has;

1. Conducted a survey of employees to bring focus to the development of TIC.
2. Implemented specific trauma training to selected front line staff.
3. Incorporated TIC discussion to all staff meetings.
4. Mapped out a plan to incorporate consumers in the delivery of services.

And is:

5. Currently developing an on-line training module to be rolled out to all staff including volunteers.
6. Revising all policies and procedures to ensure a TIC focus

WM Each site has conducted an audit of its physical environment including signage, reception, client waiting areas and counselling rooms. As a result of this certain signs that had previously been deemed to be acceptable have now been removed.

VFP What is the next step for WM in the area of trauma informed care and practice?

WM As the working committee draws to a conclusion we are now identifying and implementing ways TIC can be kept alive and dynamic. Ongoing training and inclusion of TIC discussion in all staff meetings are considered an essential part of this process.

For more information about Wesley Mission's programs and services visit: www.wesleymission.org.au

For more information on Trauma Informed care and Practice training visit: www.mhcc.org.au/learning-and-training

Gambling and mental health, what's the deal?

FOR MOST people, gambling is a fun, social activity; an occasional bet, buying a lottery ticket, playing the pokies or a night out at the casino. However there is a growing body of evidence that for some, gambling brings loneliness, shame, isolation, anxiety and depression. Recent studies from Victoria also show a strong link between gambling and suicide (Read more http://bit.ly/11GiNRt). There is also evidence that for every person who gambles problematically, 5 to 10 others are affected, including family, friends and employers.

> **... for every person who gambles problematically, 5 to 10 others are affected, including family, friends and employers.**

Mental health and gambling can be linked in several ways:

- Gambling can negatively impact on mental health; there is evidence that shows problem gambling increases anxiety and stress across a range of domains including financial, housing, legal and relationships.
- People are more at risk of problem gambling if they are isolated, bored or lonely, have financial problems, have a history of mental health problems, have been abused or traumatized, or have problems with alcohol or other drugs.
- A person's problem gambling can impact on the mental wellbeing of the whole family through feelings of shame and embarrassment, loss of trust, isolation, family arguments, depression, fear, financial issues and hardship, loss of property and valued items. Children whose parent experiences problems with gambling are more likely to experience problems with gambling themselves.

Organisations that support people with complex needs should consider: How much do you know about the impact of gambling on mental health consumers and their families? Is this something your service routinely screens and assesses for? Do you feel confident working with consumers who are impacted by problem gambling?

Problem gambling carries a burden of shame and secrecy; therefore it can be hard to know if someone is negatively affected by gambling.

New to the Professional Development Series – *Gambling and Mental Health*

The purpose of this two day workshop is for participants to:

- gain a greater understanding of the profile of gambling in Australia
- feel more confident to raise the issue of gambling with consumers
- be aware of a range of screening tools to assess the impact of gambling on consumers' lives
- further develop skills for talking with consumers about gambling
- be aware of a range of approaches for supporting a person to address gambling as part of their recovery, including motivational interviewing, cognitive behavioural therapy, harm minimisation and working alongside specialist gambling and financial counselling services.

Our trainers make the difference

Alison Bell has a background in Mental Health Nursing and Psychology. Alison has over 20 years' experience as an educator and trainer, and has delivered thousands of workshops to professionals from mental health, drug and alcohol and community services on a range of topics including motivational interviewing, substance use and mental health, working with coerced clients and relapse prevention. Alison has been involved in developing and regularly facilitating courses on gambling for a number of years in NSW, funded by the Responsible Gambling Fund, and in Canberra for the ACT Gambling and Racing Commission. Alison also works as a nurse in mental health and drug and alcohol services on the Central Coast of NSW.

Alison also delivers *Motivational Interviewing* as part of MHCC's Professional Development Series of workshops. For more information or to book visit: www.mhcc.org.au/learning-and-training

MHCC ACTIVITIES – AT A GLANCE

Key Projects details on website www.mhcc.org.au:

- Aged Care
- Community Mental Health Drug and Alcohol Research Network (CMHDARN)
- CAG & MHCC 'Recovery Resource' Project (ROSSAT) Review
- MHCC Sector Policy Resource
- Mental Health Rights Manual – 2013 updates
- National Disability Insurance Scheme
- Psychological Injury Resource
- Practice Supervision
- Physical Health
- Practice Placements Projects
- Partners in Recovery
- Sector Benchmarking Project
- Supervision practices in MH community managed organisations
- Service Coordination Strategy
- Social Enterprise Development
- Trauma Informed Care & Practice

MHCC on behalf of CMHA:

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

Submissions:

- Department of Family and Community Services: Reforming NSW Disability Support: Legislative Structure and Content. Discussion Paper
- Office of Fair Trading: Model Rules under the NSW Associations Incorporation Act 2009: Division 2s35
- Premiers Council on Homelessness
- Physical and MH Community Sector Activities – National Summit
- FaHSCIA – NDIS Rules Consultation Paper
- Standing Committee on Law & Justice: Inquiry into the consolidation of Tribunals in NSW
- MHDAO – Defining the role of NGO Peaks
- Creative Arts Australia

MHCC facilitated and/or presented at the following events:

- Presentation to Mental Health Council Australia & USA Guests Trauma Informed Care & Practice
- CMHDARN Seeding Grants Forum
- Day to Day Living Conference
- MHCA National Election Consultations
- 2013 Learning & Development Graduation
- St Vincients Partnership Forum
- Consumer Activity Network Conference

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