View from the peak

A quarterly publication from the Mental Health Coordinating Council February 2015

Partnerships for Health

THIS YEAR is shaping up as a very intense one for community organisations particularly with reference to the NSW Health Ministry's *Partnerships for Health* (P4H) community sector reform process beginning to take shape and likely to impact services in fairly major ways over the next 12 – 18 months.

The Mental Health and Drug and Alcohol Office (MHDAO) is holding a forum on February 20 designed to provide the first formal notifications of the Ministries directions for P4H to the mental health and drug and alcohol community sectors. As a combined event, attendance has been restricted to one representative per health funded organisation. Representatives from LHDs and Medicare locals will also be present.

MHCC strongly advocated that clarity on the reasons for and desired outcomes from the P4H recommissioning of mental health and drug and alcohol community sector programs be a particular focus of the February 20 forum. The disruption to services from a reform of this nature needs justification and transparency of purpose will likely improve outcomes as will giving the sector adequate time to organise and position themselves for purchasing opportunities.

Other important advocacy by MHCC is contained within our *Briefing and Recommendations* paper on P4H which raises considerations and advocates a range of purchasing and administrative principles to assist the Minister's Office, MHDAO and the MH Commission understand the views of our membership. MHCC has been participating in dialogue with both MHDAO and the Minister's Office on the developing P4H agenda and this paper represents our best advice in response to current understanding of the P4H directions. However it must be recognised that P4H is a developing reform process in the mental health and drug and alcohol sectors and MHDAO appears open to consultation with the sector and open to improving on some of the less than optimal outcomes from similar reform processes such as the Going Home Staying Home recommissioning of homelessness services recently conducted in NSW.

The **Briefing and Recommendations** paper is available on the MHCC website on a newly established webpage dedicated to the **P4H reform process**. This webpage will provide regular updates on P4H related information and links. In addition MHCC members can sign up to receive our newly introduced *Reform Activity – Mental Health* Newsletter created to update members on the range of reform activities including: P4H, NDIS, NSW MH Strategic plan, pilot models such as 'Like Minds' and LHD service design reforms. **Click here** to subscribe if you are a MHCC member.

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'Like Minds'

Another important reform introduced early this year has been the launch of the 'Like Minds' service in Penrith managed by Uniting Care Mental Health. MHCC has long advocated this service model which aims to ensure people with complex mental health issues can access support in aspects of their life from a single 'one stop shop' in the community. The model allows for the co-location of support services that are able to assist people with issues around, for example, housing, family

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Penrith MP Stuart Ayres (left), Penrith councillor Bernard Bratusa (centre) and Mental Health Minister Jai Rowell at the opening of the LikeMind site at Penrith

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planning, education, employment as well as GP and psychological services.

Perhaps the most innovative aspect of the service model however, is that it co-locates public mental health, private and non-government providers in the same building allowing for assessment, triage and referral to be a far more streamlined, coordinated and consumer-directed experience for the person seeking support and their family and carers.

Minister for Mental Health, Jai Rowell is very supportive of the 'Like Minds' approach to service delivery and has announced funding allocation of $2million for two additional 'Like Minds' services in NSW. At this stage the locations of these services have not been announced but it appears there is now growing and widespread support for co-location models that aim to reduce the siloing of services and prioritise the consumer experience.

Jenna Bateman
MHCC CEO

MHCC ACTIVITIES – AT A GLANCE

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

- Community Mental Health Drug and Alcohol Research Network (CMHDARN)
- Monitoring Safeguards Mechanisms
- NSW Mental Health Rights Manual Review
- National Directions in Mental Health Workforce Development (on behalf of CMHA)
- National Disability Insurance Scheme analysis and impacts (in partnership with NSW MHC)
- National Outcome Measurement and Minimum Data Set Projects (on behalf of CMHA)
- National Strategy for Trauma Informed Care and Practice (TICP)
- Partnerships for Health (P4H) - Ministry of Health Mental Health Program Approach
- Peer Work Qualification Development Project
- Peer Work Qualification Pilot
- Peer Work Champions Project
- Practice Placement Project Enhancement
- Recovery Orientation in Youth Mental Health and Child and Adolescent Mental Health Services (CAMHS: Research Project)
- ROSSAT Psychometrics Projects
- Trauma Informed Care and Practice Organisational Toolkit (TICPOT)
- Work Integrated Learning Project

Key Submissions Comment

- Physical Health Project Proposal – Supporting Consumer Physical Health Project: Meeting the physical health needs of consumers in the community in NSW
- IPART Issues Paper May 2014: A fair and transparent fee structure for the NSW Trustee and Guardian (NSW TG)
- Submission to the Australian Law Reform Commission (ALRC): Equality, Capacity & Disability in Commonwealth Laws: Discussion Paper 81
- Launch of NSW Mental Health Strategic Plan – Media release
- Partnerships for Health – Briefing and Recommendations paper

MHCC facilitated and/or presented at the following events

- TheMHS Conference 27-29/08/14
  - Development of the MH Peer Work Cert IV
  - Featured Symposium: NDIS
  - Report from NDIS Hunter Trial Site
  - ROSSAT Phase 2
  - National CMO Outcome Measurement Project
- Second Biennial Australasian Implementation Conference, Sydney 17–18/09/14
- National Hoarding and Squalor Conference 19/09/14
- Hunter NDIS and Mental Health Community of Practice Forum 30/09/14
- National Respite Association (formerly Interchange) Annual Conference 23/10/14
- MHCC CEO and Senior Managers Forum 03/12/14
- Hunter NDIS and Mental Health Community of Practice Forum 16/12/14

Meet the 2015 MHCC Board

IN DECEMBER, MHCC welcomed two new members to the **Board** – Jenny Hall of Neami National and Michael Sheedy of Wesley Mission – along with the re-election of Karen Burns, Leone Crayden and Sue Sacker. And while MHCC looks forward to working with fresh perspectives in 2015, we would also like to acknowledge the considerable contributions of Dr Cathy Kezelman and Sylvia Grant, whose experience and energy have helped shaped MHCC for more than five years.

L to R: Michael Sheedy, Jenny Hall, Jenna Bateman and Karen Burns at the 2014 MHCC CEO and Senior Management Forum.

Jenny Hall

Neami National

Jenny holds the role of National Manager, Services at Neami and has previously held the role of State Manager – SA/WA. She has extensive career experience in the fields of acute and community based mental health, community development, aged care and training. Jenny has qualifications and training in Leadership and Management, Governance, Social Work and Counselling.

In her role Jenny provides strategic oversight to all aspects of Neami's operations across 5 states and she is particularly interested in capacity building in the sector and knowledge sharing. Neami is currently supporting and mentoring the Sunrise Aboriginal Health Service in NT to deliver their first PHaMHs service.

Jenny is committed to mental health sector development and reform and has contributed in a range of forums including as a Board member and President of the Mental Health Coalition of SA. She has served as a member on the SA Health and Community Services Complaints Commission Advisory Council since 2010.

Neami National is a community mental health service supporting people living with mental illness to improve their health, live independently and pursue a life based on their own strengths, values and goals. Neami provides community outreach support, housing and homelessness support, prevention and early intervention programs and service coordination in over 40 diverse communities in Western Australia, Queensland, South Australia, Victoria and New South Wales, ranging from the inner-city and suburbs to regional and remote areas.

For more information visit:
www.neaminational.org.au/

Michael Sheedy

Wesley Mission

Michael works as Executive Manager of Wesley Mission's Mental Health and Counselling Services. He oversees Wesley Mission's mental health hospitals at Ashfield and Kogarah, Suicide Prevention Services (Lifeline Sydney/Sutherland and Wesley LifeForce), Counselling Services (problem gambling, financial and psychological counselling) and Wesley's operations in Newcastle and Central Coast regions.

Prior to joining Wesley Mission in 2008, Michael worked in senior management roles in the corporate sector. Previous board experience includes Anglicare Sydney (2005-2009) and Anglican Youthworks (2010 to present). Michael is keen to help MHCC continue to support and strengthen the community mental health sector for the ultimate benefit of mental health consumers, their carers and families.

Wesley Mission has been supporting Australians in the community for over 200 years. They provide a wide range of services across family, youth, aged care, disability, homelessness, counselling, employment and training, carer and mental health.

For more information visit:
www.wesleymission.org.au/

Further Unravelling Psychosocial Disability:

Experiences from the NSW Hunter NDIS Trial Site

WE HAVE NOW passed the 18 month mark for activity related to mental health and psychosocial disability within the NSW NDIS trial site. This is the half-way point in the three year trial and much learning has occurred for us as a result of the important partnership between MHCC and the NSW Mental Health Commission.

It won't be long now until we begin to see the roll-out of the full Scheme across NSW commencing July 2016. The program for this to occur may be known from July 2015 thus allowing opportunities for communities outside of the trial site to more concretely plan. Organisations operating outside of the three LGAs that make up the Hunter trial site are urged to consider what the NDIS might mean for them in terms of organisational readiness and service delivery.

At our September Hunter NDIS and Mental Health 'Community of Practice' (COP) Forum we heard more positive stories from the NDIA, HNEMH and Partners in Recovery (PIR) about people's access to and experience of the NDIS. The NSW Ombudsman's Office also presented on their enhanced role under the Disability Inclusion Bill 2014 (NSW). They are keen to hear from people with mental health conditions and service providers in the Hunter with lived experience of the NDIS and will soon be convening a focus group to do just that.

MHCC was invited recently to present in the mental health stream at the October National Respite Association Conference held in Sydney. The situation for family and carer support services under the National Disability Strategy, including but not limited to the NDIS, continues to lack clarity. At this conference MHCC learned that the mental health sector is behind the disability and aged care sectors in regard to shaping the future for family and carer support services. This must change.

MHCC and the Mental Health Commission held the final COP Forum for 2014 on December 16. The forum focused on what Tier 2 – now known as 'Information, Linkages and Capacity-building (ILC)' supports – might look like. We were delighted that Eddie Bartnik – who is an independent Strategic Adviser to the NDIA on mental health, Local Area Coordination and community capacity building – joined us for this discussion, along with Ability Links and PIR. Eddie shared with us that two national projects will soon commence. One will explore NDIS access for people with mental health conditions and the other will consider the types of supports required and costs associated with these. These projects will inform future data collection requirements.

Our understanding is that NSW Health funded community sector mental health programs, which are not 'in-scope' for the NDIS, will be an important part of Tier 2/ILC of the NDIS along with a range of new providers who may enter the market. There are important discussions that need to occur about how the NSW Health 'Partnerships for Health' reforms might contribute to the operationalisation of the NDIS.

MHCC has completed a comprehensive report for the NSW Mental Health Commission on the NSW 2013/14 experience of the NDIS from a mental health sector perspective. The report captures much of the learning to date and makes suggestions for priority actions and activities to take our work forward. 2015 will bring with it many new opportunities for improved access to community-based services and supports for people affected by mental health conditions. We look forward to continuing to work with our members and others to maximise these.

For more information about the NDIS and psychosocial disability please visit: **mhcc.org.au/policy-advocacy-reform/influence-and-reform/ndis-and-mental-healthpsychosocial-disability.aspx.**

Eddie Bartnik speaking at the December NDIS Community of Practice forum in Newcastle

PROPOSED DIRECTIONS OF THE NSW NDIS AND MENTAL HEALTH ANALYSIS PARTNERSHIP PROJECT

MHCC and the NSW Mental Health Commission are now calling their NDIS partnership the *'NSW NDIS and Mental Health Analysis Partnership Project'.* Directions proposed for taking our shared work forward are:

1. Effective representation and participation of consumers, their families and carers, and mental health service providers in NDIS implementation and evaluation.
2. Increased recognition and understanding of the needs of people affected by psychosocial disability.
3. Pursue collaborative, recovery-oriented and trauma-informed health and wellbeing approaches to services and supports planning/review processes.
4. Research and development analysis of trial site experiences including the collection of comprehensive data.
5. Development of strategic directions for NDIS psychosocial disability and recovery support workforce development.
6. Influence development of the framework for NDIS quality and safeguard mechanisms in NSW and nationally.
7. Contribute to the national discourse regarding the NDIS and mental health.

The activities to achieve these directions are now under consideration and include continuation of the Hunter NDIS and Mental Health COP Forum.

Mental Health and the NDIS – the Partners in Recovery experience

Sally Regan, Partners in Recovery Operations Manager – Hunter Medicare Local, expands on the PIR experience in the Hunter trial site.

The introduction of the National Disability Insurance Scheme (NDIS) caused many individuals and groups to express strong concerns about the implications of the scheme for mental health consumers, carers and service providers.

The Hunter is unique in that it is the only adult NDIS launch site in the country that also has a Partners in Recovery (PIR) Program in the first year of operation. Therefore, it would seem an appropriate time to review how the NDIS and the PIR program has been working together.

PIR links people with the services they need and works to fix issues at a systems level so people with severe and persistent mental illness and complex needs do not fall through the gaps. PIR has a multi-faceted role that engages with hard to reach populations and works with them to find and/or purchase services to meet their needs, and support recovery goals.

Unlike PIR, the NDIS was not designed specifically for people with severe and persistent mental illness. However, both programs have the mutual goals of providing information, referring to services, improving access, meeting individual needs and aspirations and modifying the service system including capacity building.

Currently, in the Hunter fifty (50) consumers are registered in both PIR and NDIS and there are thirty-two (32) applications pending. There are approximately 229 registered PIR clients in the Hunter NDIS trial site (Newcastle, Lake Macquarie and Maitland). In total, PIR has helped twenty-six (26) consumers lodge applications with nine (9) of those applications being declined. This may indicate that a high percentage of people with a

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> **"The NDIS has benefited the consumers greatly. They have so much flexibility now with their lives and of course choice in who they want in involved in their lives. A lot of great things are happening...for the first time services are asking them "what can we do for you?". Now it is the consumers that can go shopping for services and purchase the ones they want."**
>
> Feedback from a Satisfied Hunter Boarding House Proprietor

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severe mental illness are being excluded from the NDIS. Our experience leads us to conclude that while there is potential for the NDIS to support more PIR consumers this has been limited for a number of reasons including:

- A significantly cumbersome application process that deters PIR Support Facilitators and consumers
- Long wait times for an NDIS plan to be developed
- PIR consumers do not require the additional support from the NDIS
- Ineligible for the NDIS.

Hunter PIR is currently contracted to provide "in-kind" support to the NDIS and is the preferred NDIS mental health provider for *'Assistance in coordinating or managing life stages, transitions and supports'* (Coordination of Supports). This work includes assisting the consumer with budgeting, developing capacity and resilience in the participant's network, coordinating complex supports, life planning and resolving crisis situations.

While all this work is vital we remain concerned that the real value of PIR is not being recognised by the NDIS currently. PIR is at its core a whole person based approach and from our experience the NDIS is focused on the functional deficits of the individual. The pitfalls of this approach for people with severe and persistent mental health issues is that people may be excluded because they will minimise or even hide the impact of their illness.

Hunter PIR Support Facilitator Providers:

aftercare – together for social and emotional wellbeing

Wesley mission

benevolent society

neami national – Improving Mental Health and Wellbeing

medicare local HUNTER

RichmondPRA – Together, we're better.

"PIR links people with the services they need and works to fix issues at a systems level so people with severe and persistent mental illness and complex needs do not fall through the gaps."

A key lesson learnt at Hunter PIR is that individuals who slip through the gaps in the system require the most effort to engage; it is imperative that we are persistent, flexible and not give up. Many people, often those with the highest needs in our community, are being excluded and marginalised and work must be done at the system level to prevent this happening. PIR is doing this work. Hunter PIR is building partnerships and strategies to meet system issues. Some of these include:

- Enhancing support from General Practice
- Redesigning the service system response when someone is acutely unwell
- Improving pre-release planning from Corrections
- Recruiting and training Aboriginal Cultural Mentors.

Work in this area is only just beginning but the continuing partnership with the NDIS is demonstrating that the work of PIR is essential if the NDIS is to achieve its goal of providing support to everyone who needs it.

Missed an Issue? You can download back issues of View From the Peak at mhcc.org.au or download them HERE >

The Mental Health Amendment (Statutory Review) Act, 2014

AMENDMENTS ARISING from the review fall predominately into a number of areas particularly important to people with lived experience receiving services that interface with the *Mental Health Amendment (Statutory Review) Act*, 2014. Broadly these amendments relate to recovery principles, consumer, carer rights and community treatment orders. MHCC are pleased to note that 'promoting recovery' is a concept to appear in the Objects of the Act, and that the Principles of Care and Treatment in the Act will identify the critical importance of supporting people with a mental illness or a mental disorder to pursue their own recovery.

The amendment promotes involving people with lived experience in the development of their recovery plans so that their views and expressed wishes are considered. These principles also include the aim requiring that every reasonably practicable effort should be made to obtain the informed consent of people with a mental illness or a mental disorder in the development of treatment and recovery plans.

The amended Act has created a new entity of 'principal care provider' who will generally have the same rights to notice, be consulted and to make requests as the 'designated carer' (formerly the 'primary carer'). It would seem that this amendment has been added to ensure that the person who actually provides the care is 'in the loop'. When the amendment is in force, the Mental Health Review Tribunal will be able to discharge a person at a mental health inquiry, or at an involuntary patient review, into the care of their designated carer or principal care provider. MHCC welcome these amendments as a move towards recovery-orientation across service systems.

Read a summary interpretation of the main changes to the Act by Professor Dan Howard SC, President of the NSW Mental Health Review Tribunal.

click here to read more

For further information contact Corinne Henderson at **corinne@mhcc.org.au**

In order to read more about the new provisions, you can read the Act, which can be found on the NSW Parliamentary Counsel's **website**.

National Minimum Data Set delay shifts focus to NSW Health data policy

THE MENTAL HEALTH Information Strategy Standing Committee (MHISSC) has written to the state and territory mental health peak bodies to inform them that the NGO Establishments National Minimum Data Set (NGOE NMDS) has been indefinitely delayed due to a lack of commitment from jurisdictions to resource collection. This means that jurisdictions can still use the data items developed up to this point; however there will be no commitment by the states to collect or report on the data set. This is a major setback for the sector as the NGOE NMDS was the most promising method of gaining a standardised and publicly reportable collection of basic CMO data.

The mental health CMO sector has struggled to gain visibility in public reporting of mental health service delivery. After the shelving of the NSW Community Managed Mental Health Data Management Strategy, the MHCC worked for a number of years with the Commonwealth Government on behalf of CMHA to develop a national collection that would mandate NSW collection of basic organisational information. Without the momentum of a national minimum data set the onus is on the NSW Government to deliver on the recommendation of the NSW Mental Health Strategic Plan to better manage, collect and resource CMO data collection.

> **"The mental health CMO sector has struggled to gain visibility in public reporting of mental health service delivery."**

The MHCC has written to the NSW Ministry of Health requesting that it incorporate the NGOE Data Set Specification into its upcoming Partnerships For Health reform process with the intention of progressing toward a sector-agreed NSW mental health CMO minimum data set.

Primary Health Networks – What do we know for sure?

MHCC RECENTLY INTERVIEWED Ian Sinnett (pictured), Interim Executive Director, GP NSW to give his organisation's perspective on what the impending reform of Medicare Locals (scheduled to cease operation on the 30 June 2015) and establishment of Primary Health Networks (PHNs), might mean for the community managed mental health sector.

Ian suggests that establishment of PHNs, "represents one of the most revolutionary changes to primary health care in recent times." He reports PHNs will work to improve frontline health care through primary, community and secondary health sector integration and that continuity of services for patients is a priority in establishing PHNs and transitioning MLs. Ian went on to say, "There is a new focus on commissioning rather than purchasing services, potentially through joint needs assessments with Local Health Districts, requiring a new type of relationship with providers."

MHCC asked Ian what he understood to be the driver for this primary health care reform, coming so swiftly on the back of the earlier establishment of the MLs that as a sector MHCC and its members worked so hard to partner and collaborate with? To this Ian responded that it emerged out of the Horvath Report – which reviewed Medicare Locals to consider all aspects of their structure, operation and functions, and to provide advice on future directions.

This report has influenced how the new PHNs will perform, in that they will:

- Jointly conduct extensive mapping and needs assessments, identifying gaps in health services and work in partnership to provide appropriate services
- Link parts of the health system to allow it to operate more effectively and efficiently
- Integrate care through collaboration with health professionals and services to facilitate a seamless patient experience
- Fund providers to deliver clinical services. Clinical services can only be provided in areas of market failure
- Improve patient outcomes across the entire health system, focussing on reducing admissions, readmissions and lengths of stay
- Establish GP led local clinical councils including broad allied health membership and LHD representation; the councils will work with Community Advisory Committees to inform PHN Board on regional priorities and investment strategies
- Work with GPs, private specialists, Local Health Districts, private hospitals, aged care facilities, Indigenous health services, NGOs to establish clinical pathways of care for people with a chronic disease
- Provide general practice support activities specifically focussing on the adoption of relaunched electronic health records.

Interested to understand the difference between MLs and the newly formed PHNs, Ian advised MHCC that "...as with Medicare Locals, Boards will be required to be skills-based. However, it is understood that there is flexibility around potential models and that the same model will not apply across the board. With the Federal Government's intention to increase flexibility and decrease compliance and micro-management of the new PHNs, it is hoped that the capacity to formulate both governance and operational structures for the PHNs will be significantly self-determined."

And what about the new boundaries and potential new entrants?

"The publication of the boundaries provides nine PHNs for NSW: North Coast, Western Sydney, South Western Sydney and Nepean Blue Mountains Medicare Locals' boundaries are unchanged. However, it should be noted some of these areas are experiencing significant population growth. Like in other areas of the health system, these MLs will be required to compete for PHN status. The remaining ML areas are also negotiating new partnerships and alliances to cover much larger and diverse geographical areas. It is presently unclear whether existing Medicare Locals will merge governance structures or form new entities, potentially with

> **"Horvath stated in his report that "... today's health care needs are very different. The burden of disease has shifted to chronic illnesses – which call for a continuum of care – and fundamental changes in the health care workforce".**

broader partnership interests". Ian advised, "Many are tight-lipped about their negotiations, as possible new entrants are exploring their potential application for PHN status".

Ian went on to say that, "...undoubtedly, many new PHNs will have to develop a local or satellite office networks to maintain close engagement with their communities. A key challenge will be communication and relationship building, together with sustaining existing local engagement as organisations and players may change."

GP NSW's perspective seem to indicate that whilst Health Minister, Peter Dutton expects there to be radical differences between MLs and PHNs, in truth, there is likely to be limited difference between what both primary care organisations are expected to do, but major change in how they will do it! The Department of health will set new national targets for reducing admissions in certain areas, increasing immunisation rates and reducing smoking prevalence, amongst more locally agreed KPIs. In addition, new organisations, commercial players and consortia may tender for the PHN contracts. External probity advisors are already being enlisted to assist the Department of Health with private sector applicants.

What about contestability? Ian replied that, "Competition is set for PHN status, together with an expectation to manage the market for delivery of new services. They are likely to divest from provision by 2016 of any services except where there is demonstrable local market failures and with agreement from the Department. It is unlikely that Medicare Locals will focus on becoming exclusively' provider' organisations; most will pass service responsibility to existing partners or have an arms-length relationship. The longer term principle is intended to open up markets to 'not-for-profit', 'for profit' and new entrants to create efficiencies and innovation. Interestingly, the landscape is set for better performing PHNs to take over those who do less well."

Ian noted, "Surviving a competitive culture is key. We are witnessing some increased caution across the landscape, especially from potential for new entrants. Some potential applicants are reluctant to share information or declare interest for fear of losing commercial advantage. Fact is – we will need stronger collaborative and trusting relationships to focus on new service design and comprehensive solutions as expectations grow."

The Department has made it clear that unlike the move from Divisions of General Practice to MLs in 2012, this is not a transition from MLs to PHNs but a distinct policy reform change. In relation to existing MLs, Ian commented, "We now see a process of competition for PHNs and some transition, where MLs can continue to provide services into 2016 with Department agreement.

The closing date for PHN applications was 27 January 2015. Watch this space closely in March 2015 to learn who the PHNs will be from 1st July 2015.

For more information, visit: **www.health.gov.au/internet/main/publishing.nsf/Content/primary_Health_Networks**

Recovery orientation in Youth Mental Health and Child and Adolescent Mental Health Services (CAMHS)

RECOVERY-ORIENTED practice is embedded across numerous Australian mental health policy frameworks and practice standards including the National Framework for Recovery-Oriented Mental Health Services, the National Standards for Mental Health Services (2010) and the National Practice Standards for the Mental Health Workforce (2013). However, there is little evidence as to what 'Recovery' means from the perspective of young people. There has been a tendency in youth mental health services as well as child and adolescent mental health services (CAMHS) to use different language in models of care which do not necessarily align to the 'recovery' literature.

Early in 2014, a study was initiated by MHCC and MH-Kids which set out to look into the experiences of young people, their families and mental health service providers to better understand what recovery meant for them. Since recovery was originally defined from the narratives of adult mental health consumers, their families and carers, it is unclear as to whether these concepts are immediately transferrable to the developmental context of child, adolescent and youth experiences of mental health support. Therefore, how recovery concepts and practices may be consistent with their needs is important to consider. The main aim was to explore and discuss the utility and

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relevance of the themes identified in the adult personal recovery literature to children, young people and their families.

Concerns have been raised that the specific needs of children and adolescents will be overlooked if they are provided with exactly the same services and models of care as adult services (Friesen 2007; Lal 2010). Consultations in the USA (Friesen 2007) have shown that when given information about recovery, service providers, young people and their families are all able to identify the utility of recovery philosophy, provided it is implemented in a developmentally appropriate, contextual manner.

The main findings of the review are that the five recovery processes: Connectedness, Hope and Optimism about the future, Identity, Meaning, Purpose and Empowerment (summarised as CHIME) are relevant for young people, although how these are expressed will depend on their age and developmental stage. Part 1 of the paper published in December 2014 presents a background to the concepts and issues based on a review of the literature as well as a summary of concerns expressed in existing literature about the application of recovery principles to children and young people. Part 2 outlines the findings from consultations conducted with three stakeholder groups: young people who have been diagnosed with mental illness; parents and caregivers; and mental health professionals who work with children and young people. Their perspectives on the utility of recovery concepts and recovery-oriented practice for the needs of children and young people are discussed. Lastly, Part 3 outlines suggested practice guidelines to assist with the implementation of recovery-oriented practice for children and young people. It also makes recommendations for further work needed to assist with the implementation of recovery-oriented practice in mental health services for children and young people.

The Report can be accessed on the **MHCC website**.

Hoarding and Squalor in NSW and the value of taskforces

IN SEPTEMBER 2014 the report *Beyond Overwhelmed was launched*, outlining the issues relating to hoarding and squalor and the services currently available in NSW. This was the culmination of three years of work by the NSW Hoarding and Squalor taskforce, which comprised representatives of all relevant NSW government agencies and many community stakeholders.

After the inaugural National Hoarding and Squalor Conference was held by Catholic Community Services (CCS) NSW & ACT in 2011, leading advocates, directors of government agencies, consumer representatives and peak bodies agreed to establish an ongoing taskforce auspiced by CCS to investigate current responses to the issue and develop a way forward for NSW.

The challenge laid out from the 2011 conference was that primarily the issue of hoarding and squalor is seen as "no-one's problem" – making it everyone's problem. International literature has for some time pointed toward the need for coordination, collaboration and joined up service responses. In terms of government response, there isn't clear evidence on whether there is a need for specialised hoarding and squalor services in every region, however where they don't exist the report identified a clear need for close cooperation between contacting agencies.

The report identified a clear need for close cooperation between contacting agencies

The NSW Hoarding and Squalor Taskforce included representatives from the Ministry of Health, Department of Families and Community Services, Housing NSW, NSW Fire & Rescue, RSPCA NSW, Homelessness NSW, local council representatives, and the NSW Trustee. There were also consumer and carer representatives and Professor John Snowden, an eminent Psychiatrist with expertise in hoarding and squalor.

The issues that were brought to the attention of the taskforce varied depending on their origin.

> **It was important to continually return to the terms of reference and remind each other that a taskforce is not just an interagency, it must remain focused on outcomes and find new ways to solve the problem at hand.**

Community services agencies were focused on practical and psychological client-related concerns. NSW Fire & Rescue were required to approach the issue from a safety and legal perspective, as were many local councils. The RSPCA contributed an animal-rights legal perspective. The Ministry of Health described the problematic nature of this issue due to the majority of people with hoarding and squalor issues tending to be outside the boundaries of a clinical diagnosis or the Mental Health Act. Ultimately there was consensus that there are major systemic shortfalls to the NSW Government hoarding and squalor response.

Complicating matters was the period of NSW Government reforms that saw major cuts to the number of jobs in departments. Many Government representatives were replaced with lower-level staff. Government stakeholders also became strongly focused on solutions that didn't require any new spending. Non-government stakeholders came to the conclusion that there was a major service gap that is the responsibility of the NSW Government.

As the nature of the taskforce changed, there was a point where momentum waned and the meetings turned more toward information sharing, an easy thing to occur when you bring together policy stakeholders from across different sectors. It was important to continually return to the terms of reference and remind each other that a taskforce is not just an interagency, it must remain focused on outcomes and find new ways to solve the problem at hand.

By 2013 it was possible to establish commitment to develop an issues paper identifying what the problem is, how it is responded to in NSW, and what good practice exists elsewhere. The Issues Paper aimed to:

- explain hoarding and squalor
- review the literature, including psychiatric & psychological understandings
- review Australian responses and what exists in NSW
- identify the most common contact points (Local councils, animal protection & fire services)

- provide an overview of evidence-based interventions
- describe best-practice response approaches, such as service coordination and trauma informed care
- give guidance for risk management
- discuss issues around the current legal framework
- provide links to tools and resources
- highlight the key actions required to achieve systemic competence, including government leadership, the need for statewide guidelines, better data and research, and the need for legislative change.

Once the issues paper was finished the non-government members of the taskforce provided a clear set of recommendations to the Premier and Minister for Families and Community Services based on the findings of the report. The Minister has agreed to meet with Catholic Community Services and MHCC to discuss the recommendations.

The taskforce process was more involved and laborious than most interagency processes. However there was strong value in the taskforce model by virtue of the clear information and recommendations that were developed with cooperation and endorsement across the human services. When such a large gap exists in the system the solution is only realistic when all the major stakeholders work together toward a shared goal.

Beyond Overwhelmed: Identifying pathways to deliver more effective services for people and their pets affected by hoarding and squalor across NSW is available to download from **www.hoardingsqualorconference.com.au**

CMHDARN UPDATE July–December 2014

THIS SECOND HALF of 2014 continued to broaden the reach of CMHDARN and develop new relationships with researchers and specialist research centres, as well as membership of CMHDARN continuing to grow. This period also saw a focus on overseeing two external projects - one evaluating the CMHDARN program and the second, developing a new resource. Funding was also secured for a further twelve months through the ongoing partnership with the NSW Mental Health Commission.

Of particular note are the following achievements:

1. Recognition of the work of CMHDARN by sharing the inaugural Tom Trauer gold award for Research and Evaluation at TheMHs conference held Perth 2014.
2. The commissioning of a best practice online guide and resource to support the improvement in the effectiveness and processes by which organisations engage consumers and carers in their research and evaluation work. This will offer a lasting resource for people in the two sectors, with a broad range of ideas, templates and suggested resources.
3. CMHDARN held its first targeted research forum focussed on working with Aboriginal communities. New relationships developed through the planning and conducting of this forum were made with the Lowitja Institute (Melbourne) and the Healing Foundation (Canberra).
4. Presentation of a paper on the work of CMHDARN entitled *"Research into practice – lessons from a network approach to the challenge of implementation"*, at the 2nd Australasian National Implementation Conference held in Sydney in September 2014.

Dr Julie Mooney Sommers and Dr Nicola Hancock at the December research forum

Consultation in action at the December 2 Navigating Research Ethics forum

CMHDARN website

The **website** continues to be utilised and is one of the means of distributing information about CMHDARN upcoming activities and links to registration forms. It is also a means of accessing materials from past CMHDARN activities, relevant research related resources, potential research funding and background to the formation of CMHDARN.

CMHDARN Research Forums

- Strategies for Building Research Capacity in your Organisation'' Ballina, 3 July 2014: 29 registrations
- Understanding Best Practice Research when Working with Aboriginal Communities and People, Sydney 7 August: 50 registrations
- Navigating Research Ethics, Sydney 2 December: 25 Registrations

Reflective Practice Webinars

- Improving organisational capacity and demonstrating efficacy August 12: 19 Registrations
- Integrated psychological treatment addressing co-existing alcohol misuse and depression November 25: 33 Registrations

CMHDARN Mentoring

The CMHDARN Community Research Mentoring Project continued into the second part of 2014. As part of the development of this project, an interim evaluation was undertaken during August 2014. Key results were:

General rating of program

Who?	Excellent	Very Good
Mentees (n= 4, 40% response)	3	1
Mentors (n= 5, 50% response)	2	3
N= 9	5	4

Key activities undertaken:

Activities undertaken varied considerably. Some examples are below:

- Advice on designing an evaluation for our service and specifically an evaluation survey for one part of the evaluation.
- Review of research and evaluation outcomes/ tools. How to approach development of evaluation tools
- Discussion of methodology, analysis, programs to code data (i.e. design of telephone evaluation study, including feedback on survey instruments)
- Telephone support

Way/s mentor helped you to improve your research knowledge and skills?

- *X has been excellent in guiding my research design. It has also given me an understanding of how to select the right psychometric tools.*
- *X has been able to give me good advice re survey monkey, survey design, questions to ask and to link me with other similar studies so this has been really helpful.*
- *My mentor directed me to research articles and websites which were extremely helpful*
- *Better knowledge of what research and evaluation tools are available.*

Promotion of consumer participation in research activity

CMHDARN encourages and promotes organisations to consider the role that consumers and clients play in their research activity, and how they can improve their participation.

In June 2014 a special project to develop an online resource *A guide for organisations for increasing carer and consumer/client participation and involvement in research activity* was approved in relation to improving organisations' approach to increasing participation of consumers and carers in research activity. The final draft is currently being edited and finalised.

Engaging with stakeholders

The engagement with CMHDARN during the last seven months has included:

- 249 registered CMHDARN members (December 31, 2014)
- 104 people registered for the three Research Forums
- 52 people registered for the two webinars
- 792 individual users of the website
- 23 instances of academic researcher involvement (Mentoring: 8 directly; 3 indirectly; Research Forums: 7; Reflective Practice webinars: 2; Project Reference Group: 3)

2015

This year will see CMHDARN program activities continue. The subject topics of the forums and webinars will be informed by the soon to be finalised external evaluation.

One change this year to CMHDARN's journey is that Deb Tipper is leaving the Project Officer position after three years in the role. MHCC and NADA would like to recognise and congratulate Deb on her excellent contribution to establishing CMHDARN; building the strong collaborative relationships that underpin it and setting it on a strong footing for its ongoing development. Recruitment has commenced for a new Project Officer to continue the work of the research network.

CMHDARN is a partnership between MHCC, NADA and the Mental Health Commission of NSW

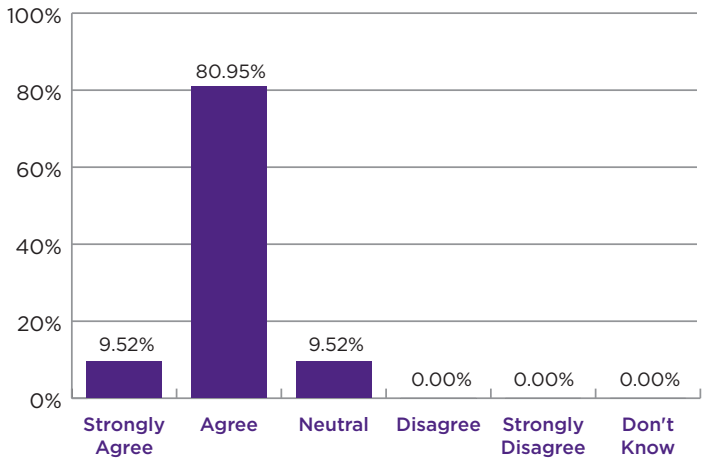
CMHDARN encourages and promotes organisations to consider the role that consumers and clients play in their research activity, and how they can improve their participation.

2014 Members Survey

IN 2014, MHCC continued its commitment to meaningful engagement with its membership. Along with a range of events and activities in 2014, members were invited once again to participate in the annual member survey. MHCC would like to thank those who participated in this valuable opportunity to share their opinions regarding MHCC products and services.

MHCC received 90.47% *Agree to Strongly Agree* responses for having outstanding performance for the past year, resulting in an average score of 75.00 (see figure). Among the services provided, 'Seminars/Forums/Workshops' received the highest score of 86.90. The two resources which received the highest usefulness scores were the 'Recovery Oriented Language Guide' and the 'Community Mental Health and Drug & Alcohol Research Network (CMHDARN)'.

Question – 'MHCC's overall performance has been outstanding':



Members were also asked to rate the importance of the advocacy activities of MHCC in influencing government which received an average importance score of 86.25. MHCC's weekly e-newsletter, FYI e-news, continues to be rated the most popular communication channel. (If you aren't on the mailing list, you can **Subscribe to FYI here**).

And MHCC Learning & Development (LD) continues to rank highly amongst members with 43% of the respondents indicating that they have participated in MHCC LD courses or activities in the past 12 months.

Suggestions received included: continuing to assist in transition to NDIS; expansion of services; provision of training or conference opportunities in regional and rural NSW; assistance with supported decision-making processes; and implementation of resources such as ROSSAT.

Congratulations to ASCA for winning a Kindle in the Member Survey prize draw!

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