View from the peak

A quarterly publication from the Mental Health Coordinating Council June 2014

Budget blues

AUSTRALIA is becoming a harsher place if you are young, unemployed or on a Disability Support Pension, and especially if you are person with an ongoing mental health condition that isn't acute enough to guarantee NDIS eligibility! If opposition to the Government's budget fails to halt the proposed cutbacks, those people particularly affected will find their meagre entitlements further eroded. We are deeply concerned at the lack of understanding that exists in Government circles concerning people who are often poor, socially isolated and experiencing daily discrimination and stigma.

The National Commission of Audit's Report (the basis on which the Government's budget was developed) coldly states that mental health service delivery is characterised by 'overlapping funding and service delivery responsibilities and a lack of coordination across jurisdictions'. The National Mental Health Commission, (who we are pleased to hear will be further funded for the time being) has been asked to pay particular attention to 'removing the significant duplication between the Commonwealth and the States that currently exists in mental health services' in its review of mental health programs and services.

Mostly what we see at the coal face is inequitable access and the absence of a raft of services, particularly for people who are managing their recovery well, but need improved supports to better their quality of life in the community. Often severely stretched finances impact a person's ability to progress recovery. A major concern is what we observe as both Commonwealth and State governments attempting to abrogate responsibility for the most vulnerable in our society. While in NSW we are pleased to hear that the Ministry of Health's strategy will be responsive to the need to better realign services from the public to the community sector, we are concerned that it is the 'Richmond Report' all over again. In reality services are losing their funding across the mental health and human services sectors and referral pathways are mostly contracting.

Commonwealth initiatives to improve service and care coordination in primary health is now compromised by the rug being pulled out from under the Medicare Locals, even though we understand that under another name (Primary Health Care) funding will recommence. The Commonwealth has walked away from the National Health Reform Agreement leaving a $1.2 billion hole in the NSW Health budget, so no one needing any kind of public health service will remain unaffected in NSW. Our best hope is that as nothing is set in stone and that

A major concern is what we observe as both Commonwealth and State governments attempting to abrogate responsibility for the most vulnerable in our society.

many initiatives outlined in the budget will likely stumble at the first hurdle in the lower house or be blocked in the Senate.

We urge the sector to be vocal and advocate where and when it can. MHCC will continue to strongly promote our sector and we are encouraged that the new Minister for Mental Health, Jai Rowell has demonstrated an interest in a number of areas of concern to MHCC, particularly the physical health of mental health consumers, and

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the need to support workforce training and professionalisation.

Whilst we congratulate the NSW Government for rejecting the hospital charges presented in the Commonwealth Government's budget, we emphasise that a safety mechanism must be established ensuring that, mental health dollars are spent on mental health activities, and that the community sector retains capacity to deliver services across the state, ensuring that people disadvantaged by mental health conditions are not further marginalised. Let sense prevail – so we can all pull together and get on with the important work at hand.

Corinne Henderson
Acting Chief Executive Officer

Acting up

With Jenna Bateman overseas on long-service leave until early October, MHCC has been placed in the capable hands of senior policy staff members, Corinne Henderson and Tully Rosen.

Corinne Henderson – Acting CEO

Corinne joined MHCC in 2003 while she was completing a Masters in Counselling and Applied Psychology. Working primarily in policy and legislative reform, particularly in relation to human rights, she has been at the forefront of the development and push of policy and practice directions to implement trauma-informed care principles across all human service sectors in Australia. Corinne represents MHCC on numerous committees including the Justice Health Forensic Network, the HCCC Community and Consumer Committee, NCOSS Health Advisory Committee, and NSW Health Interagency Reference Group.

Originally trained in textile design in the UK, Corinne worked in the home furnishings industry for over 25 years in England, South Africa and Australia, holding senior design and marketing positions in private and publicly listed companies. She is a practicing psychotherapist and clinical member of the professional associations CAPA and PACFA, and was appointed to the NSW Mental Health Review Tribunal in 2011. She recently edited the non-fiction work: *The Knife and the Butterfly: A story of Jungian Analysis*, Naomi Lloyd, 2014 published by Karnac, UK.

Tully Rosen – Acting Deputy CEO

Tully works in the areas of government systems, research, evaluation, and housing. During his 15 year involvement with the mental health sector he has led or contributed to a number of state and national sector development projects, including inter-agency quality improvement and population modelling activities. Tully sits on a number of NSW committees for the MHCC, and advises the eight state mental health peak bodies (through Community Mental Health Australia) on information, infrastructure and evaluation issues.

Tully is also a board member of The Mental Health Services (TheMHS) Learning Network and a regular contributor to TheMHS conferences and summer forums. In 2007 he made an oral history film on the Australian mental health consumer movement which headlined an exhibition at the Campbelltown Arts Centre. This won a state council award, and contributed to the filming of an ABC 'Enough Rope' special at the following TheMHS Conference (*Angels and Demons*, 2008).

Language matters

MHCC HAS long been involved in heated discussions about the use of language in the mental health sector. The MHCC Recovery Oriented Language Guide, developed with our members in 2013, went some way towards clarifying our thinking on this. Reflecting on this as a team, MHCC recently identified concerns about the terminology used that refers to people with, or having, a 'mental illness.'

Across the organisation whether in correspondence, policy and position papers, advice, responses to external publications, consultations, legislation, or in-house training; a variety of terms and perspectives exist amongst MHCC staff and its members. These differences reflect the diversity of views and variable terminology used in the mental health sector and in the broader community. We felt it necessary to determine consistent language where possible for use across the organisation.

We acknowledge that in some contexts it is problematic to utilise a term other than 'mental illness' particularly as it refers to matters relating to the *NSW Mental Health Act* 2007 or where the document references other sources using the term, and so to use a different descriptor would be confusing. However, after much thought, we have concluded that the least stigmatising and most broadly appropriate language is 'mental health condition'. The National Mental Health Consumer and Carer Forum in their publication *Unravelling Psychosocial Disability* (2011) opted likewise to use this terminology.

The rationale for this choice is as follows:

'Mental health condition' – in our view is values neutral. It is a term that provides minimal description and therefore when used demands that it be contextualised in the way that is specific to its purpose at the time.

Some other terms were considered before coming to this decision, including 'mental distress', 'mental health problems', 'mental health issues', and 'psychosocial disability.'

Mental 'Distress' – we propose denotes a state of ongoing anguish or difficulty that may not reflect every person's experience of having a mental health condition. While periods of distress may have occurred in the past, or take place in the present or future, many people live well in the community, managing their condition across the continuum, and may require support at any point in their journey.

Mental health 'problems' – in our view denotes a 'problem' that has to be 'dealt with' or 'solved'. It is a deficits-based perspective that may be perceived as judgemental of lived experience and is far removed from a recovery oriented strengths-based approach to the experiences a person might have. Conceptualising a mental health condition as 'having a problem' tends to lead practitioners to 'do to' rather than support the concept of 'dignity of risk' and 'working with'. The term may be used to characterise symptomology, therefore its meaning is in the 'eye of the beholder' and could misleadingly represent an individual's condition or the difficulty experienced.

Mental health 'issues' – we suggest is too broad, and could trivialise a person's lived experience. While possibly well-intentioned, the term implies a high level of political correctness. Commonly used in youth contexts, this term may be chosen so as not to magnify the diversity of experiences young people grapple with. Yet to suggest that binge eating, anorexia, bulimia, anxiety disorders, social anxiety and depression are "issues" is to dismiss the potential for serious consequences for an individual. Nevertheless, we accept the need to refrain from pathologising people, and proactively engage young people in discussions without scaring them away by the unnecessary use of jargon.

'Psychosocial disability' – is frequently use refer to a complex mix of difficulties that a person might experience, that involves both psychological and social aspects; which may relate to social conditions and mental, developmental, cognitive and physical disability. The term therefore denotes the complex experience across many domains that need to be considered when supporting a person engaging with services. However 'psychosocial disability' is a functional description that overlaps with, but may not encompass, the full range of biological, psychological, social, and cultural phenomena that often coexist for people experiencing mental conditions. This is discussed in the excellent *Unravelling Psychosocial Disability* (2011) discussion paper released by the National Mental Health Consumer and Carer Forum.

This article represents the first of such conversations. MHCC welcomes input on this and future ***Language Matters***, please forward comments to Corinne Henderson at corinne@mhcc.org.au

Changing attitudes and actions through education

IN RESPONSE to a number of high profile mental health related incidents, the NSW Police Mental Health Intervention Team (MHIT) introduced a two-tiered training system for frontline officers. Inspector Joel Murchie, Commander of the MHIT spoke with VFP about how this training is changing the way police work with people who have mental health conditions.

Without doubt, the most powerful component of the intensive four day MHIT course (delivered by REMIND[1]) has been the Consumer/Carer Family Perspectives Panel. The panel consists of two consumers and a carer with lived experience of schizophrenia. Panel members spoke about what it is actually like to live with, or care for someone with, a mental health condition. This was followed by frank and illuminating small group Q and A sessions. 'What we have found from feedback is that the consumer/carer panel component provides an extremely positive and invaluable insight, which links the theory we teach – to real life experience.' Inspector Murchie said.

An evaluation of the training pilot identified that many consumers felt that police were fearful of them and that 'this fear inadvertently led to the escalation of events.'[2] Encouragingly, officers who have completed the training reported an enhanced understanding of mental health related issues and an increased level of confidence in responding to mental health crisis events.

"I think we are achieving tremendous success in changing attitudes towards mental health and related issues within our organisation through our two-tiered mental health training system. We are working hard to reduce the stigma surrounding mental illness and raising the level of empathy our officers have for mental health consumers and the challenges they face. We are also actively promoting the transition of consumers into care and on to recovery in the least restrictive and most dignified way possible. This includes our aim to significantly reduce the number of instances where police vehicles transport a mental health consumer in crisis to hospital for assessment, and instead use a clinically supervised and ultimately more dignified transport in an ambulance."

Officers refine their communication and de-escalation skills with role play activities

One of the first steps taken when the MHIT was initially established in 2007 was to form a collaborative and effective working relationship with key mental health service partners. This resulted in the secondment of a fulltime mental health Clinical Nurse Consultant to provide expert advice and appropriate content for our training programs. The Schizophrenia Fellowship of NSW was also a key player in the establishment of the MHIT and in facilitating the consumer and carer input which is changing attitudes and perceptions around mental health and illness.

The new one day workshop, which commenced in February 2014, will be delivered over a two year period to 13,500 officers across the State.

Continued >

"With the implementation of the new one day workshop, we have provided the NSW Police Force with a world class, and dare I say world leading, two-tiered mental health training system that ensures all officers receive a minimum of one day's intensive training with selected officers transitioned to the more expansive four day program to become MHIT badge wearing specialists."

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And while funding and logistical issues currently prevent the inclusion of face-to-face consumer and carer panels in this program, short films of personal stories have been produced with funding assistance from the Mental Health Commission of NSW. The one day workshop is also a subject for all recruits at the NSW Police Force Academy at Goulburn. The University of Wollongong, Faculty of Forensic Mental Health has also been engaged to undertake an independent review of the one day MHIT program as it rolls out statewide in addition to a re-evaluation of the original MHIT concept and direction.

1 REMIND is the training division of SFNSW

2 2009. Charles Sturt University, Centre for Inland Health Australian Graduate School of Policing

"I particularly enjoyed the consumer's panel. It helped affirm the fact that people [with mental health conditions] should be treated with dignity."

MHIT graduate

Preparing for new funding relationships with NSW Health under the Grants Management Improvement Program (GMIP)

THE NSW Health Integrated Care Branch continues to consult with peak bodies on the support needed to help organisations transition to the new funding arrangement that will begin in financial year 2015/16. Community managed organisations (CMOs) currently receiving NGO Grant Program funding will have been contacted by the Ministry to negotiate new KPIs for their funding agreement to develop contracts for 2014/15.

MHCC recommend that care be taken in negotiations to properly specify the services that your organisation delivers for these contracts, including any special activities that add value to the services you are being contracted for. The KPIs that have been agreed for 2014/15 will be used to inform the Ministry's tender EOIs for 2015/16.

MHCC is discussing opportunities with NSW Health to provide training and resources to support CMOs 'get ready' for the competitive tendering process in 2015/16. From a preliminary analysis, some key skills have been identified for CMOs that are more likely to be successful:

- Strong quality, governance and risk management processes
- Information and evaluation systems
- Documented outcomes that your service demonstrates alignment with NSW Health targeted needs
- Tender writing and contract management skills
- Demonstrated capacity for partnerships and/or consortia arrangements

CMOs should also seriously consider mergers, consortium-building or other partnership arrangements when tendering for 2015/16 as the Ministry of Health has clearly stated that it will be seeking to procure services from fewer organisations over time.

MHCC intends to maintain its focus in advocating for further and enhanced support to members during this transition period. In the meantime we welcome your comments on specific areas of skills development that MHCC can provide. Please contact Tully Rosen via email at tully@mhcc.org.au

Further information:

www.ncoss.org.au/content/view/5404/111/

www.health.nsw.gov.au/business/partners/Pages/latest-news.aspx

The Australian policy environment

WE APPRECIATE that members are busy people, inundated with endless papers, reports and emails to read and news to keep up with. So it often goes unnoticed that MHCC regularly respond to a raft of broad-based policy reform matters in the mental health and disability context and proactively lobby concerning matters that might otherwise go under the radar if we moved our eye off the ball.

In this last quarter we undertook a number of submissions including a response to a National Mental Health Commission (NMHC) *Review of Mental Health Services and Programmes*. This review fulfils a Coalition election commitment which the Government stated is aimed at delivering mental health services and programmes more 'efficiently and effectively'.

The NMHC engaged with state and territory governments and other stakeholders and invited submissions to inform their deliberations. This review sought to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing 'mental illness' to engage productively in the community.

The final report will be provided to the Government by end November. Whilst supporting the stated objectives, in their submission MHCC expressed concern that this is primarily an exercise to identify where cuts might be made without sufficiently cross referencing to the National Service Planning Framework. This was a major activity involving considerable contributions from across the sectors, which to date has not been made publicly available, and in our view is absolutely necessary to appropriately undertake long-term service planning.

MHCC also responded to a national enquiry from the Australian Health Ministers' Advisory Council (AHMAC) concerning the *National Code of Conduct for Health Care Workers*. In our submission we suggested that the proposed scope of application of the National Code requires further clarification on the applicability to community sector workers.

While 'mental health' is listed as being in-scope for the code, its' applicability to community sector practitioners is vague. Nevertheless, the Code will largely complement and likely lead to quality improvements made to required and voluntary codes of conduct that may exist for specific professions and workforces.

Unfortunately, some unregulated and unregistered practitioners may not be aware of their obligations under the code, and an effective communication strategy will be necessary to inform unregulated practitioners.

We also provided comment on the first review of services delivered by the NSW Trustee and Guardian (NSWTG) since the controversial amalgamation of the Office of the Protective Commissioner and the Public Trustee in 2009. Conducted by the Independent Pricing and Regulatory Tribunal (IPART), the review focused mainly on a fair and transparent fee structure, however, the review also offered an opportunity to comment more broadly.

Consumers, particularly those unable to advocate for their needs and assert their rights, must be protected by society. None of us know when we might be in need of support and protection ourselves.

MHCC have been led to understand that many NSWTG clients, their families and carers are less than happy with the services they receive since the merger. Whilst services are more broadly available across regional areas, the quality of service has deteriorated. This is thought to be primarily due to the loss of expertise resulting from the merger, and those officers handling financial matters having little knowledge and understanding of the complexity, and co-existing difficulties that many consumers experience. A degree of frustration is also expressed about accountability.

MHCC strongly advocated in their submission, that KPIs are developed in consultation with consumers and carers to establish benchmarks for satisfaction and evaluation of service delivery over time. It is important that independent scrutiny be established and complaints and appeals published, rather than just identifying problems through root cause analysis. We appreciate that there is a correlation between service cost and quality, but it is important that standards are met whether paid for by the consumer or the state.

Consumers, particularly those unable to advocate for their needs and assert their rights, must be protected by society. None of us know when we might be in need of support and protection ourselves. It is an important safety net for the community as a whole.

Submissions are available from the MHCC website at www.mhcc.org.au/policy-advocacy-reform/influence-and-reform/mhcc-submissions.aspx

A collective consumer and carer voice shapes national qualification for peer work

WITH THE advent of the nationally recognised Certificate IV in Mental Health Peer Work, the National Mental Health Commission (NMHC) funded Community Mental Health Australia (CMHA) to develop national learning and assessment resources for this qualification. MHCC commenced coordination of this project on behalf of CMHA in early 2013, engaging a broad national network of peer work expertise.

This work progresses aims of the Fourth National Mental Health Plan to expand and train this emerging workforce, cement the role of peer work in the mental health sector. Since the national training package for the Certificate IV in Mental Health Peer Work became available in 2012, few Registered Training Organisations (RTOs) have the training available due to the rigorous resource development requirements.

From August this year, the suite of resources required for this qualification will be available to RTOs across Australia. This will be distributed by the National Mental Health Commission at no charge, enabling greater access and choice for peer workers wishing to undertake this pivotal training.

The project is in a steady phase of resource development. The technical reference group, with expertise in peer work as well as development of accredited training, met to review draft resources in May. This enabled review of content areas such as peer work in the workplace, defining carer peer work and peer led research, with members drawing together knowledge of key pieces of work achieved in the sector for inclusion in the resources.

The National Consumer and Carer Peer Work Qualification Reference Group (pictured) met in June to refine units of competence, such as 'Supporting physical health and wellbeing' and 'Working effectively in Trauma-Informed care'. This is a highly expert group of 24 dynamic, experienced peer workers and service representatives across public, private and community sectors, which have shaped key content and structure of the training for final recommendation by the National Management Steering Committee.

If peer support is understood as a reciprocal exchange based on respect, value of lived experience, shared responsibility, and mutual agreement, these core values have also catalysed a process to draw together the diversity of Australian peer work expertise and distil this in to a high quality consistent learning resource to support the future of peer work.

PEER WORK QUALIFICATION PROJECT

Feedback shared by reference group members demonstrates the importance and impact of this work:

> **This is a watershed project and one of the most exciting, ground breaking advancements for peer work in decades. These resources are world class and will assist in increasing the credibility and profile of peer workers across Australia. – Michael Burge, OAM**
>
> **'What I love is that no one organisation owns this. This is a collaborative thing that came from shared knowledge and collaboration, we can all be proud of it.'**
>
> **'.. after seeing the resource book and reflecting on the experience I had at work in the past, I can appreciate the breadth of content in the book could have solved a lot of the heartache I had along the way. This is going to propel the workforce forward.**

For more information, please contact:

Chris Keyes – Project Manager at chriskeyes@mhcc.org.au

The National Consumer and Carer Peer Work Qualification Reference Group meeting in June

Strong partnership provides regional carer respite

THE *Haven Project* is a community mental health respite program based in Macarthur assisting carers of a person with a mental health condition. The Haven identity and service model, sustained as a partnership/consortium over the past five years has created ongoing opportunity for carers to access support and education flexibly.

The success of this long term partnership began with a sound establishment phase during which time clear objectives and strategies were developed, along with trust and agreement between all partners. This process was facilitated by a 'partnership broker', acting as a third party, enabling a focus on developing creative respite options and avoiding /minimising the competitive element. Importantly, the consortium continues to be strengthened and regularly reviewed to reflect environmental and strategic changes over time.

The *Partners in Respite: Building Capacity in Community Mental Health Family Support and Carer Respite Project* was funded by the former Australian Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) is now renamed the Department of Social Services (DSS). The project now falls under the *Mental Health Respite Program*. The Project aimed to address carer respite needs at the local level and gave clear recognition to the value of effectively setting up partnerships. MHCC received funding to provide Project Officers (acting as 'brokers') to support the development of three regional partnerships in the lead up to the consortia tender application, and initial set up for successful applicant.

In 2009, Anglicare and a number of community organisations active in the Macarthur area worked with project officers from MHCC to develop a new regional approach to carer support, respite care and education for families. Anglicare was chosen as the lead organisation of a consortium of five organisations to create the *Haven Project*. Consortium partners are Macarthur Disability Services, Illawarra Wingecarribee Disability Trust, Wollondilly Community Links and BCD Community Care. The objective was to enable the consortium to develop a system of flexible, integrated respite services to support families and carers of people with mental health issues in the region whilst also developing an income stream to sustain service provision and complement potential Commonwealth funding. The consortium and service proposal was chosen via a national tender process and was one of three funded in NSW.

From left: My Yen Tran (formerly of Anglicare), Julie Deane (Macarthur Disability Services), Cheryl Tarantola (Anglicare), Kim Stace (Community Links Wollondilly), Bronwyn Hindson (BCD Community Care), Michael Mittwollen (Anglicare), Peg Ludwig (Disability Trust Southern Highlands)

A regional model for mental health carer respite was developed as the consortium went through a partnership process involving:

- scoping
- information sharing
- needs analysis and information gathering
- establishment of consortium
- development of service model
- formalisation of partnership
- development of tender
- operational planning
- implementation
- monitoring and evaluation.

Haven consortium members still speak of the value of the MHCC involvement in the development of the partnership: '[The 'broker'] was a good investment to the project. They removed an individual focus [as organisations] and supported a creative approach to respite development as a partnership. We had to talk things through, work together and decide who was in the best position to host various roles', says Michael Mittwollen, Manager of Anglicare for South West Sydney (pictured).

The partnership is underpinned by important processes bringing commitment to roles, outcomes and shared accountability. An operational Memorandum of Understanding (MoU) was developed and continues to be reviewed to reflect changes over time.

Haven consortium members are senior level staff, and five years later nearly all remain involved having been in the development phase. They

continue to meet monthly to discuss issues and projects: 'Meetings are never routine. We always plan and consult as a group of organisations together and this has kept the relationship going', Mr Mittwollen said.

While all organisations work under the one Haven consortium project, each organisation has individual responsibility for staff performance on the Project, while the consortium partners together address broader project/service issues.

The *Haven Project* is now an established regional identity and is a first point of contact for both carers and recipients. The Haven model focuses on wellness through various service models. The Haven partnership is working to complement new mental health services in the region, including Partners in Recovery (PIR), and other carer initiatives by facilitating collaborative practice in regional service provision to carers through community networks.

For more information visit: www.havenproject.com.au/new/anglicare-2.html

Collaboration Research and Report from NSW Public Service Commission

THE PUBLIC Service Commission Advisory Board commissioned research in 2013 to provide advice on successful models of collaboration within and between the public, private and not-for-profit sectors. A report supporting collaboration between sectors to improve customer outcomes for citizens of NSW has recently been launched. Also available is a blueprint which provides an overview of the elements to consider when deciding on 'why', 'with whom' and 'how' to collaborate. It is based on a review of collaboration literature as well as insights and experience from practitioners in the public, private and not for profit sectors.

For more information, visit: www.psc.nsw.gov.au/Sector-Support/Collaboration

MEET YOUR NEIGHBOUR – STRENGTHENING LOCAL PARTNERSHIPS

MEET Your Neighbour (MYN) events continue to be well attended around NSW with increased requests from community organisations wanting to host events to support networking and relationship building across organisations and sectors at the local level.

Eleven MYN events have been held this year in order to meet demand in supporting organisations to build networks and promote new initiatives, such as Partners in Recovery (PIR).

Feedback continues to show that through MYN events, referral pathways have been established or strengthened, and consumers and carers have been better matched to programs and services in their area:

'Thank you for facilitating this forum so professionally. I made valuable personal connections with a number of local services with whom PIR is yet to meet! I especially appreciated you so effectively promoting PIR as a valuable "service linkage" service to the group.'

PIR Team Leader

Many community managed organisations value the opportunity to act as a MYN host as it provides a great opportunity to learn about organisations in their area with an interest in mental health. It also enables direct promotion of services in the local community:

'It is really important to increase our profile in the local community and I think the event enabled that! The group participation was at a good level to give each service the time required to talk about current programs and services on offer. At other events involving guest speakers, time is much more limited.'
MYN Host

'Thank you for such an informative and valuable day. As I am still quite new in my role it was a fantastic way to meet people and get to know other programs and I made some great contacts so thank you.'

To receive advice on upcoming events, subscribe to FYI e-news by emailing info@mhcc.org.au

For more information contact: Stephanie@mhcc.org.au

Meet Your Neighbour comes to Interrelate, Lismore

CMHDARN – hand in hand, step by step

Partnerships, collaboration and workforce development

CMHDARN has prefaced much of its work on cross sector collaboration and knowledge sharing, proposing that this approach is critical to enhanced understanding and skill development for the community mental health and drug and alcohol workforce. When considering research capacity building, CMHDARN has utilised the expertise and experience of the workforce, carers and consumers from within the community managed sector as well as academic researchers.

Research capacity building is a multi-stepped process and differs across organisations. The recent evaluation of CMHDARN's Research Seeding Grants Program[1] confirmed that within the community managed sector, organisations and workers are at different levels of capacity development. Variables impacting on capacity building include:

- the size of the organisation
- the existing skills available within the organisation
- the extent to which staff has access to professional development opportunities
- relationships with academic researchers, and;
- the role and importance placed upon research with each organisation.

CMHDARN offers access to affordable and broad based opportunities for workers to build research skills and knowledge. Evidence suggests that CMHDARN is achieving this. For example, the Seeding Grants Program evaluation[2] reported that all survey and interview respondents identified that the grant had increased their research capacity, regardless of their prior level of experience. Feedback from the CMHDARN research forum program also supports this view, with respondents indicating, for example, that they had improved their general research knowledge, consideration of data, and increased access to research resources.

The rich diversity of these collaborations positively impacts on the quality of CMHDARN activities.

Some examples of the CMHDARN related partnerships and collaboration and their direct benefits include:

- **CMHDARN Project Reference Group (PRG)** – the PRG is a collaboration of people representing the interests of mental health and drug and alcohol workers, organisations , consumers, carers and academic researchers, as well as across rural , regional and urban areas. Together, these people guide and support the implementation of CMHDARN 's strategies.
- **CMHDARN, through MHCC and NADA have a Memorandum of Understanding with the NHMRC Centre for Research Excellence in Mental Health and Substance Use (CREMS).** This partnership has resulted in the development of the CMHDARN Community Research Mentoring Project. This project has matched eleven mentees with mentors from the CREMS post-doctoral group. These mentoring relationships are providing support to work on workplace-related research projects, thus directly offering an opportunity to develop research related skills and knowledge. In return, the mentors are learning about service delivery realities and challenges. This has the potential to have a long term effect on the nature and process of research undertaken by these academic researchers.
- **CMHDARN and academic researchers –** CMHDARN has involved 53 different academic researchers from eleven universities in a variety of roles. These highly productive collaborations have enhanced research expertise and knowledge, ongoing relationships and important dialogue between academic researchers and practitioners. One example of this involvement was through the CMHDARN Research Seeding Grants Program. A recent external evaluation of this program (soon to be published), found that collaboration brought mutual benefits to both the community organisations and the academic researchers involved.

The rich diversity of these collaborations positively impacts on the quality of CMHDARN activities and has without doubt contributed to the development of improved research knowledge, skills and understanding across the mental health and drug and alcohol sectors. This has in turn, enhanced individual practice.

1 MHCC and NADA (2014) *Community Mental Health Drug and Alcohol Research Network (CMHDARN) Research Seeding Grants Program: An Evaluation*

2 ibid

Further unravelling psychosocial disability:

Experiences from the NSW Hunter NDIS Launch Site

SINCE the launch of the National Disability Insurance Scheme (NDIS) in July 2013, the NSW Hunter area is the only Year 1 NDIS launch site that has any significant amount of mental health/psychosocial disability activity. This includes the important interface of NDIS with Partners in Recovery. It was heartening to read in a recent Hunter PIR e-newsletter that 300 people have been referred to the new program since it commenced in November.

At the MHCC and NSW Mental Health Commission's NDIS and Mental Health 'Community of Practice' (COP) Forum in March, the National Disability Insurance Agency (NDIA) reported that 89 clients were registered with 'primary' psychiatric/psychosocial disability.[1] In addition, Hunter Mental Health (HMH) reported that they had made 63 referrals to NDIA from inpatient sites (19 people accepted and some under review). HMH are now auditing their community team referrals and identifying additional people who may be eligible for NDIA.

NDIA's reporting (December, 2013) indicated that just 2% of participants nationally accessing funded services had a primary psychiatric/psychosocial disability (i.e., 57 people). Most of these appear to be Hunter based and the number is growing. The NDIA has been very flexible where decisions need review and the volume of work means that benchmarks are beginning to emerge for scheme eligibility and access. However, the establishment of benchmarks still has some way to go and more systemic approaches to data and outcome collections would be helpful in this regard.

The skills required for effective assessment of people with psychosocial disability are complex and may require a specialist approach within the NDIS. Important concerns are arising about effective processes for transitions in care for people choosing to change providers. We also continue to be concerned about the Tier 3 eligibility of PHaMS clients with early estimates that less than 20% may be eligible. Issues have also emerged regarding processes around the assessment and eligibility of people living in boarding houses. Concerns have been raised about diminished access to hoarding and squalor programs that are ADHC funded and thus 'in-scope' for NDIS.

Consideration of the needs of people with high levels of disability related to a mental health condition continues with important ongoing discussions between the Commonwealth Government and the Mental Health Council of Australia (MHCA) about ways to maximise learnings and, thus, outcomes for consumers. This includes the MHCA having been funded to conduct the Mental Health NDIS Capacity Building Project for a further two years (2014/16).

Approximately 70 people attended the March COP Forum. A panel explored how individual and systemic consumer and carer voices are being included in NDIS implementation. Some consumers and carers tell us that they feel confused and overwhelmed by the opportunities presenting through the NDIS. Other people in the launch site who believe they have high levels of psychosocial disability are increasingly self-referring to the NDIA as they become more aware of the initiative. They report that being assessed as ineligible can be distressing for them, their families and their friends.

People can benefit from the support of PIR, their GP and/or other mental health programs and services in NDIS referral, assessment and eligibility processes. The NDIA is now reviewing all mental health related referrals deemed ineligible since the initiative commenced in June 2013.

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

HUNTER NDIS AND MENTAL HEALTH COMMUNITY OF PRACTICE

The latest Hunter NDIS and Mental Health COP Forum was held on 17 June with representatives from the NSW Consumer Advisory Group (CAG) and NSW ARAFMI attending. In addition to discussion surrounding sector concerns and updates from NDIA and HMH, MHCC will continue to discuss processes for ensuring the participation and representation of mental health consumers, carers and community sector organisations in NDIS implementation.

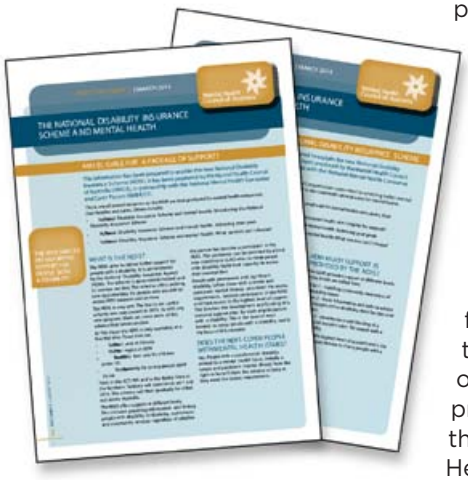
1. The terms psychiatric and psychosocial disability are used interchangeably in this article but they do not mean the same thing. Please refer to the important foundational document '*Unravelling Psychosocial Disability*' (NMHCCF, 2011) for further information.

Breathtaking in more ways than one

A much needed consumer perspective on the NDIS!

Debbie Hamilton recently shared with VFP the very real concerns and questions she and other Hunter consumers and carers have voiced about how the National Disability Insurance Scheme (NDIS) will affect them.

It is 'breath taking' being at the forefront of the roll out of the NDIS in Australia. Although reform of the disability sector promises much philosophically, implementation of the scheme will not automatically lead to good outcomes. It won't necessarily lead to evidence based practice or be in the best interest of all consumers. Therefore, we need to be vigilant.



From our experience in the Hunter it is clear that the application process is detailed and complex. There has been little attempt to create or find appropriate resources to fully inform consumers of the NDIS application process. It was helpful, though, that the Mental Health Council of Australia recently produced four documents to assist with this need.

One major problem is a lack of sophistication and complex understanding of the realm of psychosocial disability by assessors and planners at the National Disability Insurance Agency (NDIA). Good communication between the NDIA and the person with a disability is pivotal to the underlying framework of the NDIS. Consequently, there is a pressing need to develop innovative communication and planning instruments, such as the 'Ten Seed' Tool[1]. This (evidence-based) tool could, for example, be used to assess the real funding priorities of consumers during the planning phase thus ensuring that real consumer choices are heard and not determined by others.

The NDIA also does not fund (and therefore does not recognise) the very important role sexuality and intimacy (or lack of it) play in the lives of people with a disability. The lack of a planning item for this important human right further entrenches the ongoing neglect of sexuality for people with disability.

Unfortunately, a tension still exists between the (long and hard fought for) recovery oriented approach adopted in response to consumer voices in the community sector and 'clinical'/medical model perspectives which predominate elsewhere.

On applying for the NDIS, consumers have to be assessed as 'disabled' as possible in order to qualify for support funding. This is of particular concern given that there is no systemic avenue for consumers and carers to collectively give feedback to the NDIA in the Hunter trial site about much valued recovery oriented support approaches.

Perhaps of most concern is the decision of NDIA to fund only 35% of consumers who currently attend D2DL services. In reality these people, are funded primarily because they need support with both their housing needs and to enhance their daily living skills. The result is that 65% of people with a psychosocial disability who attend and depend on D2DL services will not be funded to attend these services. It has also been alarming to witness people, who's whose lives have been radically improved through access to PHaMs, now being refused Tier 3 funding by the NDIS. It is thought that less than 20% of PHaMs clients will be eligible for funding.

The exclusion of many consumers has primarily come about as a result of the fact that the NDIS has difficulty quantifying the impact of a psychosocial disability, and therefore assessing the services needed. The NDIA does recognise 'psychiatric disability' but at this stage it seems to be weighted toward attending to medical/physical needs only, and not whole of life 'psychosocial disability' needs as recognized by the UN Convention of the Rights of People with Disability. It is imperative that we seek to work with the NDIA to develop more articulate, sophisticated ways to describe and understand the impact of a psychosocial disability.

To date, there is no meaningful provision in the Hunter NDIA office for consumers and carers from other cultures. Likewise, there are no Aboriginal or Torres Strait Islander planners or assessors. There are no-specialist multi-cultural people working in the office or people specifically trained in LGBTI issues.

In summary, the local roll out of the NDIS promises much but brings with it some major problems with delivery. Meanwhile, there needs to be a meaningful attempt to consult with consumers and carers by the NDIA. At the same time, innovative tools need to be developed to enable a truly 'person-centred' approach to be established. Finally, the NDIA must truly understand and acknowledge the complex nature of psychosocial disability so that the NDIS can meet the needs it was established to address.

1. Bruxner A, Brophy L, Wilson E. Consumer Choices about Mental Health Supports. *The Australian Journal of Psychosocial Rehabilitation*. Summer 2014.

Does a recovery orientated approach apply to young people?

MHCC's Youth and Recovery Project is currently exploring how the mental health 'recovery' approach translates to the care and support of children and young people who experience mental health difficulties. It is the first time this issue has been formally examined.

There is growing recognition that recovery is not an approach that applies equally across life stages, including younger and older people. Recovery has been a valuable concept that has provided people with lived experience of mental health conditions the hope and belief that they can live contributing lives. Recovery-orientated practice is now accepted as an important aspect of current approaches to adult mental health care. The National framework for recovery-oriented mental health services (Dept. of Health, 2013) describes the practice domains and key capabilities required for the mental health workforce to operate in accordance with the recovery approach.

Five common attributes have been found to underpin positive outcomes for people with mental health conditions: Connectedness, Hope and Optimism, Identity, Meaning in life and Empowerment (Leamy et al., 2011). At first glance these recovery characteristics may seem to be applicable to young people however on closer examination there are significant discrepancies in their practical application:

- There is growing awareness of important differences in understanding recovery through a developmental lens.
- The way young people relate to and interact with services and systems such as education, health, community services, justice and others differs markedly from adults.
- Young people's rights, their understanding of and ability to assert their rights are mitigated by their age and developmental stage.

The Youth and Recovery Project idea originated from Dr Beth Kotzse, Director, Mental Health and Young People, NSW Ministry of Health, who recognised the timeliness of exploring this issue and funded MHCC to manage the project.

There is growing recognition that recovery is not an approach that applies equally across life stages, including younger and older people.

MHCC has recommended that the discussion paper be informed by a comprehensive international literature review. Insights and specific examples reviewing outcomes of recovery approaches will be expanded through consultation with community and public sector practitioners, young people and their carers.

Areas for exploration in the discussion paper include: language; self-determination; the role of the family; the role of peers; peer support and mentoring; early intervention and recovery; service response and coordination.

The discussion paper will also provide recommendations of potential avenues for future research and awareness-raising which may help to resolve some of the disparity in the application of recovery practices to children and young people. The paper will be available on MHCC's website in July 2014.

References:

Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. 2011. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis, *British Journal of Psychiatry*. Vol. 199 pp: 445-52.

Department of Health 2013, *National framework for recovery-oriented mental health services.* Accessed 12/05/2014. (http://www. health.gov.au/internet/main/publishing.nsf/ Content/mental-pubs-n-recovfra)

Australian Kookaburra Kids Foundation

THE AUSTRALIAN Kookaburra Kids Foundation (AKKF/previously known as Camp Kookaburra) was the inspiration of founder Dianne Madden. Based on her own lived experience, Dianne realised the need for support for children dealing with a parent with a mental illness.

Together with local police, Camp Kookaburra identified 16 children that needed counselling and a break from their daily experiences. After receiving a small grant, Kookaburra Kids launched their first camp. From that small beginning in 2002, AKKF now have over 800 children on our database. In 2015, they are scheduled to hold eight camps and seven school holiday activity days.

Children that live with mental illness in the family are often socially isolated due to financial and social circumstances, fearing judgment and humiliation. As a result, these children often do not receive the opportunity to socialise, talk about their concerns or experience the opportunities that other children receive through sport and recreational activities. A study conducted by Professor Philip Hazell of the University of Sydney has revealed that 'children living in families experiencing mental illness are more than 50% more likely to develop a mental illness of their own without some form of intervention'.

Improved education in identifying children in need of support is key to understanding the familial mental health issue. Responding to children that may present issues such as a lack of hygiene, nutrition or unruly behaviour often represent a dysfunctional family environment and further investigation and support may be required.

'Kookaburra Kids has given me better understanding of mental illness, a group of friends who are always there to talk to and will understand and help without the fear of being judged, and the skills to help my dad when he needs it.' Courtney

At camp and through day activities, children realise they are not alone and their situation is not unique. They form friendships with children in similar situations and receive counselling and coping techniques during 'Chat Group' the educational component of the camp.

During Chat Group, children are provided with tools and resources to equip them to handle issues that may arise at home. Chat Group helps to build resilience and coping techniques and also gives them the opportunity to reach out for help and counselling. AKKF provide information about external services that will help them outside the program such as the Kids Helpline, school counsellors and youth networks.

AKKF recognises that children in this situation may have experienced trauma. While the camp and day activities are primarily a respite and educational service, if trauma-related issues arise, they are handled by trained psychologists who work in a voluntary capacity at camp.

AKKF camps and activities are made possible by a team of qualified volunteer leaders who provide age appropriate mental health education focusing on coping skills and building resilience. All new leaders undertake compulsory training prior to camp. This involves WHS, confidentiality, protocol and working with children procedures. Leaders must also pass a working with children check, and qualified psychologists and health professionals provide any medical and counselling support required.

Some volunteer team leaders and mentors have now returned as adults after attending the camp as children. They are an excellent example of the successes a program such as AKKF can deliver.

For more information about AKKF's camps and activities visit: kookaburrakids.org.au
or call (02) 8203 1917

Supporting people to make life changes

RECOVERY oriented practice and person-centred approaches are all about supporting people to make beneficial changes in their lives. But being informed about risks associated with unhealthy behaviours is not enough to motivate people to make changes. Unfortunately, people are creatures of habit and purposeful behaviour change is difficult to achieve, and even more difficult to maintain.

Motivational Interviewing (MI) (Miller & Rollnick 1991) is a person-centred approach which recognises that motivation to change comes from the person, and cannot be imposed from 'outside'. MI acknowledges that ambivalence is a very natural part of the change process. It is designed to explore and resolve ambivalence and to increase motivation for change. With the principles of autonomy and collaboration at its core, there is increasing interest and evidence to show MI's effectiveness within a mental health context.

MHCC Learning & Development takes you beyond the familiar expert/novice dynamic with our Motivational Interviewing workshops. Explore what lies behind reluctance to change in an environment of mutual respect, trust and knowledge sharing. Build your confidence and skills in supporting others to make life changes today.

Visit: mhcc.org.au/learning-and-development.aspx for more information.

Gambling help for the workplace

IN MAY this year, *Responsible Gambling Awareness Week* (RGAW) activities were held across Australia. In 2014, the main focus of RGAW in NSW was gambling and the workplace. The main aim was to raise awareness that some workers may be struggling with gambling and to encourage them to seek help as early as possible.

According to the Productivity Commission 2010 adult prevalence rates are 0.7% and 1.7% of the adult population for problem gambling and moderate risk gambling respectively. In addition around 5 to 10 family members, partners, friends and colleagues are affected by one person who has a problem with gambling. Some frontline workers, just like some of the people they support, may also struggle with gambling, whether it is their own or that of a family member.

Often people who develop a problem with gambling are experiencing other difficulties in their lives, such as workplace stress, depression, anxiety, grief and loss. This may also be the same for some people in the caring professions. For many people who go on to develop a problem with gambling, it also provides also an escape and a way of coping, a relief and even a time just for themselves.

The increase in the availability and accessibility of online gambling means gambling in the workplace, and during working hours, is now more possible than ever. The NSW Responsible Gambling Fund launched a guide – *Problem Gambling and the Workplace* – during RGAW to assist workplaces in identifying and responding to problem gambling in the workplace. It can be downloaded from www.gamblinghelp.nsw.gov.au/need-help/downloads-and-orders/?professionals

1800 858 858
www.gamblinghelp.nsw.gov.au
gambling HELP
PHONE • FACE TO FACE • ONLINE

Whether the problem with gambling is their own or someone else's, a worker may experience tremendous shame and often struggle alone for a solution. Like anyone else, they need to be supported to seek help as early as possible. There are many resources available for people whose lives are impacted by gambling.

DON'T WAIT – GET HELP

Call GamblingHelp line: 1800 858 858

or for helpful resources and online counselling visit:

- www.gamblinghelp.nsw.gov.au
- www.gamblinghelponline.org.au

Rhonda Woodford

Gambling Help Counsellor

CatholicCare Gambling Intervention Family Team (GIFT), Lewisham NSW

Phone: 02 9509 1148

Email: gamblinghelp@catholiccare.org

MHCC ACTIVITIES – AT A GLANCE

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

- Grants Management Improvement Program – Ministry of Health Mental Health Program Approach
- Peer Work Qualification Project
- Community Mental Health Drug and Alcohol Research Network (CMHDARN)
- Medicare Locals Engagement
- Monitoring Safeguards & Complaints Mechanisms
- NSW Mental Health Rights Manual review and rewrite
- National Directions in Mental Health Workforce Development (on behalf of CMHA)
- National Disability Insurance Scheme analysis and impacts
- National Outcome Measurement and Minimum Data Set Projects (on behalf of CMHA)
- Physical Health Research Projects
- ROSSAT Psychometrics Projects
- Sector Benchmarking Project
- Trauma-Informed Care and Practice Organisational Toolkit (TICPOT)
- Work Integrated Learning Project
- Youth Recovery Project

Key Submissions/Comment

- National Mental Health Commission: Review of Mental Health Services and Programs
- Australian Health Ministers Advisory Council: National Code of Conduct for Health Care Workers

MHCC facilitated and/or presented at the following events

- CMHDARN Fundamentals of Research Forum 15/04/14
- Developing Partnerships in Community Mental Health Forum 27/03/14
- Hunter NDIS Community of Practice 20/03/14 and 17/06/204
- Meet Your Neighbour events: Lismore 11/04/2014 and Surry Hills 12/05/2014
- Youth Recovery Project Focus Groups 13/05/2014

Did you miss our last issue?

View From the Peak is available online at www.mhcc.org.au

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