



newparadigm

HOLDING THE SPACE
DESCRIBING WHAT'S IMPORTANT
IN PSYCHOSOCIAL REHABILITATION

THE AUSTRALIAN JOURNAL ON
PSYCHOSOCIAL REHABILITATION

Spring
2015



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newparadigm

is published by

Psychiatric Disability Services of Victoria (VICSERV)
Level 2, 22 Home Street, Elsternwick Victoria 3185 Australia
T 03 9519 7000, F 03 9519 7022
newparadigm@vicserv.org.au
www.vicserv.org.au

Editorial Team

Debra Parnell: Editor,
Marie McInerney: Editorial Support,
Deborah Liebhaber: Editorial Assistant

Cover Artwork

'Untitled', Michelle Anderson

ISSN: 1328-9195

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Contributors

We very much welcome contributions to *newparadigm* on issues relevant to psychiatric disability support, psychosocial rehabilitation and mental health issues, but the editor retains the right to edit or reject contributions.

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 - » the author(s) name
 - » the author(s) position or preferred title
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EDITORIAL

Welcome to the Spring
2016 edition of *newparadigm*.



Debra Parnell, Manager, Policy and Communications, VICSERV

This edition of *newparadigm* brings together the thinking and perspectives of leaders in the Victorian mental health space, who have agreed that we need to describe what is important in psychiatric rehabilitation, in order to influence the future of mental health in this state.

The significant change and emerging issues that commenced in 2013 with the start of the National Disability Insurance Scheme (NDIS) trial sites have continued to develop and crystallise in 2014-15 across Victoria, as consumers, carers, and services have come to grips with the

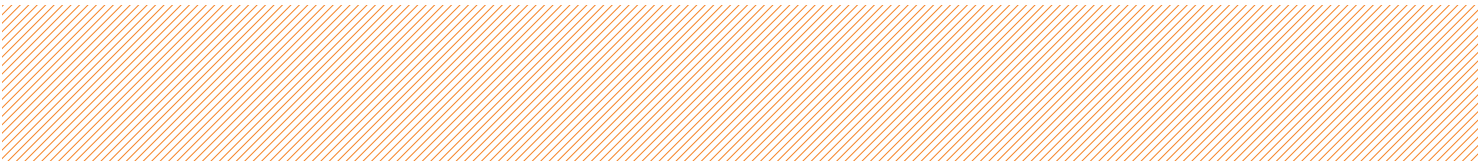
- implications of NDIS for people with mental illness
- implementation and continuing evolution of Mental Health Community Support Services (MHCSS)
- uncertainty around the availability and nature of mental health services in the future.

At this critical stage of the Victorian mental health journey, there is the potential to lose a lot that has been built up over decades of collaboration, best practice and innovation.

This edition of *newparadigm* brings together the thinking and perspectives of leaders in the Victorian mental health space, who have agreed that we need to describe what is important in psychiatric rehabilitation, in order to influence the future of mental health in this state.

Neil Tuton-Lane, Senior Consumer Consultant with cohealth, and Julien McDonald, Tandem CEO, provide the perspectives of consumers and carers on the contemporary mental health system they are looking for, while Indigo Daya, General Manager, Consumer and Carer Leadership and Advocacy, at MI Fellowship, describes the essential role of the peer workforce in this future vision.

While there are many issues raised in these articles for consumers and carers, at their base is the hope that future service arrangements will result from co-designed and collaborative processes between consumers, carers, workers, providers and governments.



Psychiatric rehabilitation is revisited and revitalised by Laura Collister, who challenges us to re-place rehabilitation at the core of community mental health support. She laments its loss from the title of Victorian PDRS services, and describes it as the line that distinguishes this sector from disability support.

Gerry Naughtin, CEO, and Margaret Grigg, Deputy CEO, at Mind, consider the role and functions of community managed mental health services (CMMHS) outside of the National Disability Insurance Scheme (NDIS). They argue that the NDIS will not replace all of the services within the CMMHS sector and that the Victorian Government will need to continue to play an important role as systems manager and funder of CMMHS. What this future role will look like and which services will continue into the future is uncertain, at this time, but they point to Victoria's investment in Prevention and Recovery Care (PARC) services as an innovative service model that has improved access to recovery-oriented support and reduced pressure on acute inpatient beds.

In attempting to describe a holistic mental health care system and how disability care is a component of this care, Arthur Papakotsias, CEO of Neami National, and Glenn Tobias, Victorian State Manager, highlight what constitutes holistic care by describing a consumer's journey through the system, dividing the journey into a beginning, middle and an end. They argue that the overwhelming majority of consumers who use mental health services do not stay in these services forever, because they **recover** to the point that they no longer need mental health services. In fact, they argue, one of the most important aspects of holistic mental health care services is that they *expect recovery to occur for consumers* rather than expecting to support people all their life.

Alan Murnane, General Manager of Primary and Mental Health at Inner South Community Health, in his article, *Innovation and rehabilitation in Victorian mental health*, argues that identifying and understanding the strengths of the existing system can inform the development of an improved system. His article focuses on the value to consumers of a funding regime that ensures availability of funds for service innovation and improvement over and above that required to provide direct service. To demonstrate the value of funding that allows service development he outlines two initiatives of Inner South Community Health – the ISCH/Alfred Health Community Psychiatry Clinic, and Engagement with the Aboriginal and Torres Strait Islander community.

Finally, we provide a summary of the key issues and recommendations identified in VICSERV's response to the Victorian Government's *10 Year Mental Health Strategy Discussion Paper*. This response is based on consultation and discussion with key mental health services, consumers and carers, and other stakeholders, and forms the platform on which VICSERV will base its future advocacy and discussions with policy makers.

In this edition's *vox pop*, we ask CEOs and senior managers from a range of organisations for their views on the future of mental health support services in Victoria, providing an interesting insight into the thinking out there at the coal face.

I would like to thank the contributors who have made this a very interesting and stimulating edition of *newparadigm* and to the VICSERV team for their valuable assistance in the production process.

I hope you enjoy reading and considering the ideas presented through these articles, and that it prompts discussion for you and your colleagues.

HOLDING THE SPACE

describing what's important
in psychosocial rehabilitation

Contemplating what a future could, and should look like: a consumer perspective



Neil Turton-Lane is a Senior Consumer Consultant in the Consumer Leadership Team with cohealth

I have been thinking about Victoria's mental health system, within the context of my own as well as other people's experiences of using mental health services. I have been doing so in the hope of being able to visualise a future built on the gains that I have witnessed, whilst remaining conscious of the significant issues that our mental health system is still yet to properly address.

As someone who spends a lot of their time talking with other consumers in my role as a consumer consultant within the MHCSS sector, the future is no distant far off destination but is instead, a space that gets inhabited daily with others.

This is a consequence of the rapidity of change in the mental health sector where over the past five years we have been cycling through a period of major, social policy-led reform. It is also recognition of the fact that consumers don't feel particularly in control of the process of reform, which for many feels imposed from above and often doesn't take into account the views and perspectives of the very people that the system seeks to serve. Within this climate, the reality is mental health consumers may well be limited in influencing change, but that sure as hell doesn't mean we are not thinking of a future where things may be different.

There is an old saying that goes something like this – "The more things change, the more they stay the same," which has a certain resonance at this point in time. For no matter what the reform or policy agenda in mental health may be, it will all be of little consequence if we, as a society, are unwilling to tackle at a very deep level the inequalities and biases that circumvent the granting of power, and the self-determination of people who live with or experience mental illness.

Encouragingly, there is movement in the air that suggests that such a time might have come. Across the nation we are in the process of implementing the National Disability Insurance Scheme (NDIS). Whilst within our own state we now have a human rights informed Mental Health Act (Mental Health Act 2014), recovery-oriented practice (Commonwealth of Australia, 2013) and the growth and development of a diverse and vibrant consumer workforce (Consumer Workforce Dialogue, 2015).

In contemplating what a future could, and should look like there are some obvious ships on the horizon that merit discussion. The biggest and most visible, but perhaps not the most important in the long run, is the NDIS. It is being packaged as a means to greater choice and control for consumers, but like most things that seem too good to be true, it has a set of serious strings attached.

In Victoria these strings include the signing over of funding that currently supports Mental Health Community Support Services and the culture and collective support, which it has over the past 25 years been able to offer to our communities. It is concerning that our governments who for so long have endorsed the mantra of evidence-based practice in mental health, are now adopting an insurance model to fund psychosocial support when no such undertaking at such a scale and level has ever been delivered in any other country in the world.

It is concerning that our governments who for so long have endorsed the mantra of evidence-based practice in mental health, are now adopting an insurance model to fund psychosocial support when no such undertaking at such a scale and level has ever been delivered in any other country in the world.

This is not to say that there is anything wrong with the concept of self-directed support (which as an idea, was born in the disability movement with a strong agenda of self-empowerment and personal agency for people living with a disability). As an approach it is admirable and has the potential to be powerful and enabling for individuals. Unfortunately, the question is not whether there is any merit in a self-directed support approach, but rather how these and other concepts are then adopted, co-opted and used by governments intent on a neo-liberal agenda of small government, and the dismantling of social welfare systems (Beresford, 2014). In this regard there are no doubt some serious lessons to be learnt from the UK, where the introduction of personal budgets and personalised services was announced with a similar fanfare and swag of good news stories about how transformative this new approach was proving to be for service users, carers and families. However, what we are now learning is that the reality for many people trying to engage with this scheme is vastly different, with service users reporting experiences of a scheme that is tightly controlled, underfunded and still very much dependent on notions of access, review and authorisation by a new and even more complex system of bureaucracy (Beresford, 2014).

For Victorians, to take full benefit of an NDIS that supports the needs of consumers, the scheme will need to remain open and receptive to the views of consumers within the National Disability Insurance Agency that will oversee its delivery. For this to take place, it will need to occur in ways that are not tokenistic, but which are instead based on the true spirit of co-design and co-production where decision-making power and authority are shared.

When thinking about the future of our mental health system, there are a number of other important matters that sit outside the ambit of the NDIS that are currently being overshadowed by its introduction, but which are equally important when considering the future mental health system needs of our communities. Many of these relate not only to our clinical mental health services but also to whatever other mental health services and supports will be available to community members in the future.

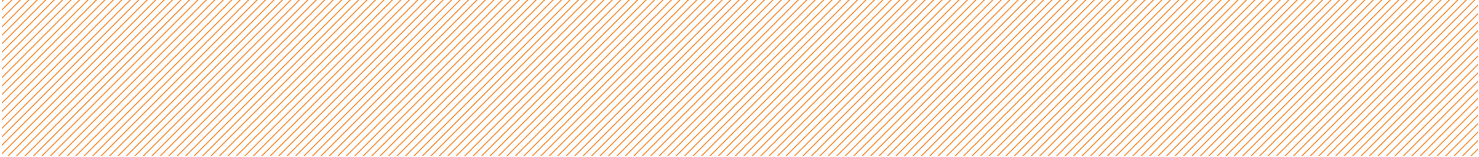
To begin with, consumers will continue to need timely, respectful and easily accessible services that can work with and for people. Consumers and carers want services that are flexible, understanding and responsive to the changing needs that people with mental health issues so often experience. Consumers deserve services that are culturally sensitive and which provide an opportunity for a diverse range of person-centred supports and options (Department of Human Services, 2009).

Our future-orientated, mental health services need to be skilled in delivering trauma-informed care and by being able to understand, recognise and respond to the effects of trauma within the lives of people that they support. Consumers would like services staffed by people with real experience, whether lived or otherwise; it really doesn't matter as long as they are passionate and considerate about the work that they do.

A contemporary mental health system needs to be able to support people in addressing the social impacts associated with living with a mental illness, in areas such as:

- Housing
- Health
- Lifestyle
- Independence
- Self Esteem
- Connection with others
- Work
- Education
- Families
- Creativity
- Sexuality
- Gender
- Ethnicity

Consumers want to see services that can offer real choices about the type of support that people can access; whether it be around the support that people need when they are unwell, or through the provision and linking to resources, education and training which assist people to live the lives they want to live.



Consumers and carers want services that are flexible, understanding and responsive to the changing needs that people with mental health issues so often experience. Consumers deserve services that are culturally sensitive and which provide an opportunity for a diverse range of person-centred supports and options.

A contemporary mental health system will have a focus on early intervention and on being available and responsive to people in times of need so that a crisis need not scale out of control. There are things that can be done to lessen the effects of a crisis. Some of these include:

- supporting people to create Advance Statements
- Individual Crisis Support Plans
- providing Peer-Run Crisis Respite Services and Warm Lines.

For people who are not eligible for the NDIS or even for people within this scheme, it will be important to provide opportunities for people to engage in communities of choice, which can support people to stay on track and remain connected with others. Communities of choice in the form of peer-led initiatives, operating independently

A contemporary mental health system will have a focus on early intervention and on being available and responsive to people in times of need so that a crisis need not scale out of control.

or in partnership can provide consumers with opportunities to engage in meaningful settings with others, where mentoring and support can assist people towards greater self-agency and empowerment.

When considering the future, isn't it time that we started questioning a mental health system which, despite the help and assistance it supplies, seems to run counter to the narratives of recovery through its heavy reliance on a bio-medical-model approach to support and care? Isn't it time that we started introducing alternative approaches to mental health, such as the approaches of Open Dialogue (Open Dialogue UK) and the Soteria Network (The Soteria Network UK), which would allow people to choose a supportive and safe mental health framework aligned with their own personal values and beliefs? Surely a truly future-orientated mental health system can learn from other evidence-based approaches if it wishes to evolve and grow.

So what is the best way to work together to co-design this new system?

The best way forward is partnership and collaboration that can provide the right environment to design a system that can address people's needs. Within our mental health system we already have abundant expertise in the shape of providers, consumers and carers who can contribute to this ongoing dialogue. The system we design together needs to capture the needs of collective communities but still recognise the specific circumstances of individuals.

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The Soteria Network UK, see <http://www.soterianetwork.org.uk/index.php>

Rehabilitation and disability support: are they the same?



Laura Collister is Director of Mental Health Services, Research & Development, at Mental Illness Fellowship Victoria

This paper seeks to differentiate existing Mental Health Community Support Services (MHCSS) from proposed disability support to be delivered under Australia's National Disability Insurance Scheme (NDIS). It proposes that these two elements are different and have the potential to complement, rather than replace each other.

Introduction

MI Fellowship has been involved in the introduction of the NDIS in multiple ways.

At an operational level, we have been delivering services as part of the NDIS transition in Barwon. As all Barwon providers will attest, this has meant considerable organisational change and high levels of involvement, some would say relentless involvement, in meetings, consultations and forums with the Department of Health and Human Services (DHHS), National Disability Insurance Agency (NDIA) and key stakeholders across our sector.

Through our advocacy program, we have consulted with carers and consumers to consider the impact of the NDIS on the lives of people affected by mental illness. We headed a forum in Barwon to explore issues from a consumer and carer perspective (previously reported in *newparadigm*), and have contributed to VICSERV, Mental Health Australia and Community Mental Health Australia forums and consultations.

'Cashing out' of services

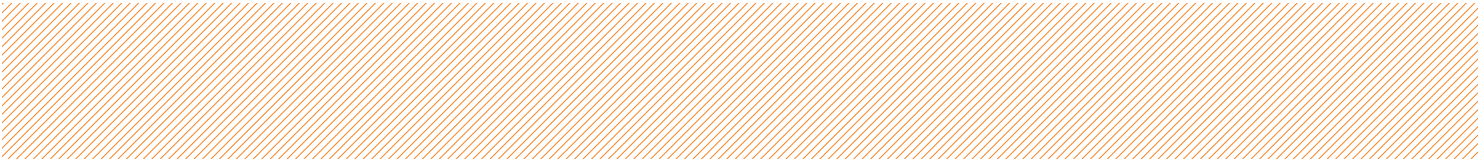
In Barwon, transitioning to the NDIS has meant that services previously funded by DHHS have been 'cashed out' to the NDIA.

For MI Fellowship, Youth Residential Rehabilitation and associated outreach funding, Mutual Support and Self Help, and some Commonwealth carer support funding is now operating under NDIA. For other providers, Home Based Outreach Support, day programs and Personal Helper and Mentor programs have been transitioned to NDIS. This cashing out of existing service types into disability support has led to significant concerns shared across the sector.

Initially, concerns were mainly focused around the pricing of support clusters. Comparing existing MHCSS prices with like NDIS clusters it became clear that the NDIS pricing was considerably lower. We felt that this would have implications on the quality of what could be offered and the technical capacity of the workforce employed to deliver that service.

Differences in approach to recovery?

All providers continue to be challenged and asked to describe exactly – how is what we do different from the NDIS? From the NDIA perspective, how can disability support offered to people with psychosocial disability be priced differently from those prices offered to people experiencing other types of disability?



Our initial response was, 'because we do recovery' (which is, of course, at odds with all we know about recovery – nobody *does* recovery to anyone, recovery is an internal journey belonging to an individual, and no service type at all). Better expressed, we felt that MHCSS services, with the knowledge base of our staff and the models we employ, placed us in a unique position to support recovery – something we felt the NDIS did not do given the proposed support clusters (which appeared very task-oriented and overly simplistic) and their related pricing.

This argument has not gained any traction. Can we truly claim recovery to be the unique province of our sector? Of course not.

Clinical treatment services, delivered by Area Mental Health Services (AMHS) in Victoria, are absolutely striving to orient their service delivery towards recovery. The National Mental Health Standards (Commonwealth of Australia, 2010) and Victorian Framework for Recovery Oriented Practice (Department of Health, 2011) apply equally to AMHS and MHCSS. There is no doubt that clinical services face particular challenges in orienting their services towards recovery. In particular, their role under the Mental Health Act and capacity to enforce compulsory treatment is perceived as a barrier for many consumers. Their resources are also inevitably drawn towards the

acute end of service delivery. Nevertheless, we would support their vision of striving towards a recovery orientation.

Our attempts to differentiate ourselves from the NDIS in terms of recovery orientation have also been problematic. The NDIS engaged a Senior Psychologist, Paul O'Halloran (O'Halloran, 2015), to write a paper explaining why and how the NDIS is recovery-oriented – how understandings of personal recovery are entirely consistent with the NDIS. The paper reminded us that recovery occurs with or without symptoms so concepts of permanent impairment – that have so worried us all – were argued as more or less distractors in the debate.

There are high profile consumer and carer advocates who welcome the advent of NDIS, with its promise of services that are personalised, chosen by the consumer and that place power in the hands of the consumer. They argue that surely these tenets are empowering and recovery-oriented – something that our clinical and MHCSS system have not delivered. Some of these advocates are critical of the current system, saying that if individuals cannot articulate recovery goals they are not engaged in MHCSS services.

I think the NDIS has made a mistake in including permanent impairment as an eligibility criteria and this argument is important. However, this is not central to our attempts to describe what MHCSS does.

Is rehabilitation at the core?

So if recovery orientation is not a differentiator of what we do, what is it that is at the core of MHCSS? Is it rehabilitation?

As a sector, I think we have baulked at this term and discarded it in favour of recovery. We have equated rehabilitation to concepts of returning the individual to a pre-illness state. This notion has been seen as incompatible with personal recovery.

I don't think many of us noticed when rehabilitation was dropped from the name of the sector when we shifted from Psychiatric Disability and Rehabilitation Support Services (PDRSS) to MHCSS. Re-examining the notion of rehabilitation has led me to a view that it does describe much of what we do in our sector, has evolved and also describes what we are fearful of losing in NDIS.

The following principles of psychiatric rehabilitation (Corrigan et al, 2008) have been identified:

- self-determination
- attention to consumer preference and goals
- real world focus
- strengths focus
- skills training
- environmental modification and support – acknowledging that community and family can influence the recovery process

The key question is whether people experiencing mental illness will be afforded the same opportunities for rehabilitation as people experiencing physical illness. This is certainly at risk in the current scenario where large portions of MHCSS funding is being cashed out to NDIS. It is unfathomable, in my view, that funding for disability support comes at the expense of rehabilitation.

Re-examining the notion of rehabilitation has led me to a view that it does describe much of what we do in our sector, has evolved and also describes what we are fearful of losing in NDIS.

- integration with treatment
- multidisciplinary approach
- continuity – moving from high intensity to low intensity supports over time and recognising that consumer needs vary over time
- community integration.

These approaches are skilled and are informed by an in-depth understanding of how illness and the experience of being a mental health consumer impacts on people's lives. Our intervention approaches are informed by evidence. There are very well established processes that guided the delivery of these services – that were used across the MHCSS sector.

Effective engagement, assessment

Effective engagement and assessment processes are fundamental to psychiatric rehabilitation. Engagement, in this context, refers to the methods we use to enlist a person in a change process, particularly at a time when they may have lost hope for recovery, feel distrustful of service systems, have few resources, or be in the early stages of recovering from psychiatric crisis.

We know that advanced level interpersonal skills are required at these times, combined with high levels of flexibility, collaboration and an in-depth understanding of recovery. For example, engaging a homeless person who is fearful of services and recently discharged from acute care probably requires a worker to 'find' the client, collaborate closely with clinical services to understand where the client might be receiving meals, and potentially activate a peer worker to create a relationship with the client. It is likely that initial engagement will focus on meeting the client's immediate needs – such as housing.

Assessment processes in psychiatric rehabilitation are comprehensive and are characterised by high levels of participation between participants, their clinical workers, and other services and involves engagement with carers and family members. Assessment involves understanding the impact of illness on people's lives, as well as the contribution of environmental factors such as exclusionary attitudes and social support.

Through the assessment process a detailed and shared understanding emerges of the person in their context, and strategies are developed that harness the participant's inherent drive, skills and resources to

achieve their recovery goals. Strategies are multifaceted – directed at an individual level to overcome illness barriers and build health management skills; to resource families and friends to understand mental illness and maintain relationships; and to enable participation in chosen communities by intervening to build individual self-efficacy and community inclusion skills.

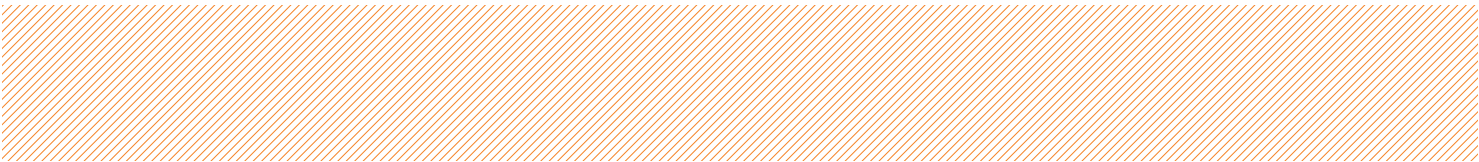
Effective intervention is dependent upon a comprehensive assessment and the relationship that is established during the assessment process. At its best, the assessment and intervention process is well integrated with treatment.

The linkage between engagement, assessment and intervention is iterative in psychiatric rehabilitation. Effective engagement underpins comprehensive assessment and enables effective intervention. Throughout the intervention process new skills are discovered, old skills reignited and supports are activated. Assessment information is modified and aspirations are broadened and become more ambitious. For example, a participant who initially wanted to just have something to do during the day changes their goal to paid employment as their sense of self-efficacy and self-management increases.

The role of disability support

The current NDIA planning processes disintegrate assessment and goal planning from disability support. Providers are engaged to provide pre-determined disability support following an assessment process that does not include those providing support. Disability support can be described as compensatory. It provides support for someone to participate in life but is not targeted at building the underlying capacity and environmental supports that is the hallmark of psychiatric rehabilitation. In this way psychiatric rehabilitation might be thought of as preventing disability.

Disability support might be considered the equivalent of providing Meals on Wheels or showering assistance to somebody with an enduring physical illness. These supports are life enhancing, both for the person who receives the support and for their carer. The NDIS is providing these supports in a way that is chosen by the individual and likely to support their recovery. This support does not preclude some skills acquisition and often does enhance participation in the community.



In the situation of a person with a physical illness who may receive the disability support described above however, they are also offered rehabilitation. This is considered a health intervention, and is delivered by occupational therapists, physiotherapists and speech pathologists. Rehabilitation is part of health, not part of an ongoing support offer, and frequently precedes disability support. Rehabilitation is designed to enhance health and prevent disability.

Disability support can be described as compensatory. It provides support for someone to participate in life but is not targeted at building the underlying capacity and environmental supports that is the hallmark of psychiatric rehabilitation.

Considering the corollary in mental health, there is some evidence that suggests that PDRSS did offer rehabilitation and disability support. Both MI Fellowship (MI Fellowship, 2015) and Neami National data (Neami National, 2015; Trauer, Tobias & Slade, 2008) indicate that active building of skills and reducing of needs occur in a time period of 1-2 years. At this time approximately two thirds of participants exit the service. The remaining one third continue engagement with the service for a longer time without significant reduction in needs.

This evidence, albeit scant, supports the proposition that rehabilitation plays a role in preventing disability. However there are certainly a group of people who, even with a period of active rehabilitation, will benefit from longer term disability support. In fact, PDRSS has offered this in the past.

The key question is whether people experiencing mental illness will be afforded the same opportunities for rehabilitation as people experiencing physical illness. This is certainly at risk in the current scenario where large portions of MHCSS funding is being cashed out to NDIS. It is unfathomable, in my view, that funding for disability support comes at the expense of rehabilitation.

This paper is based on a presentation given at the VICSERV Member Policy Forum on 12 August, 2015.

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Because mental health and carers **STILL** matter!



Julien McDonald is Executive Director of Tandem Inc

Carers are greatly concerned that the recent reform of Psychiatric Disability and Rehabilitation Support Services (PDRSS) to form the Mental Health Community Support Services (MHCSS) system did not achieve the intended outcomes.

The centralised intake system, which was intended to make the system easier to navigate, is reported by many to be unsatisfactory. Many people find the system hard to understand, the telephone screening and/or assessment difficult and they feel frustrated by the need to go through another assessment when they finally obtain service from a provider.

The reduction in the number of providers and the rapidity of the transition has created long waiting lists in some areas with many people of the highest priority referrals having to wait one month or more while less urgent referrals are unlikely to receive a service.

The change of eligibility criteria for MHCSS to align with eligibility for the National Disability Insurance Scheme (NDIS) has resulted in many people with mental illness being without the support they need to live in the community. Tandem is particularly concerned that those who fall through the gap are amongst the most vulnerable in our community. This is resulting in increased pressure on already stretched Emergency Departments and clinical services. It is also impacting on carers who are losing hope and are frequently finding their own physical and mental health is being affected.

Loss of support under NDIS

The impending roll-out of the NDIS is a further source of concern for carers as it appears that many people with severe mental illness will not be eligible for support.

According to the National Mental Health Commission, it is likely that those adults with a severe and persistent mental illness with complex multi-agency needs will be the focus of the Individual Support Packages provided through the NDIS (NMHC, 2014). The Commission's 2014 review estimates that there are 690,000 adults in Australia with severe mental illness but that only 65,000 with complex needs will be likely to access support through the NDIS. What support will be provided for the remaining 625,000 adults with severe mental illness who may not be eligible for support through the NDIS?

It is anticipated that a large percentage of Victoria's current MHCSS funding is to be transferred to the NDIS to meet the State's commitment to the Commonwealth. This is causing a great deal of concern and anxiety about how the needs of those people not eligible for the NDIS will be accommodated.

Carer well-being jeopardised

As Commonwealth carer support funding is also expected to be transferred to the NDIS, and as virtually no support for carers is



The burden on carers has already significantly increased through the decreased eligibility for mental health community support services and seems likely to be exacerbated following the roll-out of the NDIS.

available through Individualised Support Packages, there is concern that the health and well-being of carers will be further jeopardised. The burden on carers has already significantly increased through the decreased eligibility for MHCSS and seems likely to be exacerbated following the roll-out of the NDIS.

There is some hope that the Information, Linkages and Community Capacity Building (ILC) funding will provide some assistance and support to people not eligible for NDIS and also for carers. However the support to be available through the ILC is not clear and there are too many unanswered questions for carers to have any sense of reassurance.

The number one concern for carers is that the person they support is able to access appropriate services when they need it; that is, early in the illness, early in the episode and early in life. Tandem has been very pleased to hear that the Victorian Minister for Housing, Disability and Ageing, Mental Health, and Equality, Martin Foley, shares these values.

'No wrong doors'

We need holistic, recovery-focused, family-inclusive, specialised mental health support that is available in the community and well linked in with clinical services, primary health services, housing, education and employment services. A *'no wrong door approach'*, preferably at a one-stop-shop, is badly needed. An integrated system of care is required so that people are not bounced from one silo to another.

In a climate where the buzz words are hope, optimism and recovery, the prevailing atmosphere is one of high anxiety, confusion and despondency.

The workforce needed to work with people experiencing mental ill health must have specialist mental health knowledge and experience. Teams should be formed on a multidisciplinary basis and include consumer and carer peer workers with all staff having foundational skills in recovery orientation, family-inclusive practice and dual diagnosis. Teams should also be culturally competent, reflecting our multicultural community.

People with mental illness need to be able to choose from a range of evidence-based services including psychological treatments. The effects of psychotropic medications must be closely monitored and alternatives explored. There must also be provision for informal drop-in facilities (with a range of activities) providing the opportunity to socialise with peers in a safe environment. The facilities should be closely linked in to all other services to enable attendees to access the support they require when they require it.

Support for carers

Tandem's secondary, but also serious concern, is support for carers. Carers often have 24/7 responsibility. The annual replacement value of informal caring in Australia is estimated to be \$40 billion per year. Research evidence tells us that carers and mental health carers in particular have the lowest health and wellbeing of any cohort ever measured (Hammond, Weinberg & Cummins, 2013).

The NDIS provides virtually no support to carers and any support available is tied to the needs and consent of the person with the mental illness. Carers have their own needs for support independent of the needs of the person they are caring for. The number one support identified by carers is for an independent, individual, mental health advocacy service for carers similar to that available for people with a mental illness through the Victorian Mental Illness Awareness Council (VMIAC), the peak body for people with mental ill-health.

Tandem is seeking funding to provide this much-needed service which will also guide our systemic advocacy work. Carers frequently have difficulty accessing services and/or the type of help required both for the person they care for and for themselves. This causes a huge stress for carers who frequently become quite frustrated and desperate in their endeavours to find appropriate help, particularly in the early stages of mental illness.

The number one concern for carers is that the person they support is able to access appropriate services when they need it; that is, early in the illness, early in the episode and early in life.

Carers need to be able to have a break so that their own health is not compromised. Regular breaks are necessary to avoid burn out. Carers may also need access to counselling, education about mental illness and support to manage their caring role in the face of complex, distressing and challenging situations. They need access to well-resourced 24-hour help and support lines. They need to be able to make provision for when they can no longer provide care because of increasing age or ill health.

With the transfer of Commonwealth respite funding and the majority of MHCSS funding to the NDIS, carers are greatly concerned that the little support currently available to them will be further diminished and their situation will be even worse.

In a climate where the buzz words are hope, optimism and recovery, the prevailing atmosphere is one of high anxiety, confusion and despondency. A potential glimmer of hope shines through the intent

to build on the Victorian Government's 'Because mental health matters' strategy (Department of Human Services, 2009) and the commitment to listen to the voices of the people most affected by the system – people with mental ill-health and their families and carers.

Hopefully the pending new Victorian 10-year mental health strategy will be accompanied by an implementation plan and annual action plans with measurable performance indicators and outcomes as well as strong accountability provisions. A structure to actually drive this reform and ensure continuity despite changes of government is also needed. This could be a Mental Health Reform Council, or better still, a Mental Health Commission!

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Beyond NDIS – Community Managed Mental Health Services



Gerry Naughtin is the Chief Executive of Mind Australia
Margaret Grigg is the Deputy Chief Executive of Mind Australia

This article considers the role and functions of community managed mental health services (CMMHS) outside of the National Disability Insurance Scheme (NDIS) after the Scheme has been fully implemented. It argues that the NDIS will not replace all of the services within the CMMHS sector and that the Victorian Government will continue to play an important role as systems manager and funder of CMMHS.

At the time of writing this article the final decision about which community mental health services will be retained and which will be transferred to the NDIS, including Information Linkages and Capacity Building (ILC) programs, has not been announced.

However it is assumed that the majority of funding within the Mental Health Community Support Services (MHCSS) and Mutual Support and Self Help (MSSH) programs will transfer to the NDIS.

The NDIS is the most significant change to disability support, including psychosocial disability, in Australia's history. While the scheme will take some years to mature, it will deliver more support, more control and choice to participants than has been possible before. If it can deliver on its service promise, it will provide people with severe and persistent mental ill-health issues more choice and control, greater funding and a broader range of supports than has been available up until now.

An estimated 15,000 Victorians with a psychosocial disability are likely to benefit – 16 per cent more than the 12,600 people who were being supported through the previous Psychiatric Disability and Rehabilitation Support Services (PDRSS) program (Deloitte, 2013).

While the NDIS may deliver support to a large number of Victorians, there is no doubt that there will be a substantial number of people

who will not be supported by the scheme, but who would benefit from the services provided by the CMMHS sector.

The Victorian Department of Health and Human Services (DHHS) itself has estimated that an additional 32,500 Victorians would have been likely to benefit from community managed mental health services than were being supported through the PDRSS program (Dench, McClean & Carlson, 2008). This means that even after full take up of the NDIS there will still be significant need for community managed mental health services.

The evidence is clear that the Victorian Government will need to continue to have a role in the provision of targeted, evidence-based community managed mental health services that can help people to better manage their mental distress, assist them in their recovery journey and help them to build better, more meaningful lives.

While the NDIS will provide the reasonable and necessary supports for people to live lives of their choosing (whatever that may be), it will not deliver recovery and rehabilitation oriented services that have been a fundamental component of community managed mental health services. It will only target the 15,000 people with the most severe and persistent psychosocial disability, while those with less severe and episodic needs continue to be the responsibility of state-funded services.

Perhaps one of the greatest gaps that the introduction of NDIS will expose will be the provision of support to families and carers.

The continued investment in community managed mental health services is not only important in responding to unmet needs that will emerge in the post-NDIS environment, but will also be critical to reducing pressure on high cost services such as acute wards and emergency departments.

Victoria has led the nation in innovative service models to reduce pressure. For example, the Integrated Rehabilitation and Recovery Program not only achieved positive outcomes for clients; it also reduced inpatient admissions and emergency department presentations (Abello, Fisher & Sitek, 2010). In an environment where there is substantial pressure on the health budget, the efficiency and effectiveness provided by community managed mental health services cannot be ignored.

be expanded to other area mental health services. Models like extended PARCs with longer lengths of stay (such as the extended PARC operated by Monash Health) or PARCs for older people should also be explored.

There is also an opportunity to apply the principles from PARCs to community based settings. The underlying principles of collaboration, recovery orientation, least possible restrictive practices, respect and responding to diversity, consumer and carer participation, and privacy and confidentiality, can be applied elsewhere. It is time to consider the development of PARC-like services in the community; that is, implement community mental health teams that are partnerships between clinical services and community managed mental health services. Across Victoria there are numerous successful examples

The evidence is clear that the Victorian Government will need to continue to have a role in the provision of targeted, evidence-based community managed mental health services...

The Victorian Government should focus its investment in community managed mental health services on ensuring access to psychosocial services to those people with episodic needs and building innovative service models that reduce demand for high cost care.

A clear example of this has been Victoria's investment in Prevention and Recovery Care (PARC) services. This innovative service model has improved access to recovery oriented support and reduced pressure on acute inpatient beds more efficiently and effectively than traditional services. It is not surprising that other states are looking to replicate the model.

However the time is right to explore opportunities to expand the model. For example only three youth PARCs (YPARCs) have been established, providing early intervention to young people. As Victoria grows and invests in youth mental health services, YPARCs should

of co-location of these services, ensuring that broader psychosocial needs such as housing and employment are more readily available for consumers. With the NDIS set to disrupt many of these relationships, investing in psychosocial rehabilitation support for those people who will not (and probably should not) be eligible for the NDIS is critical.

The current Victorian Royal Commission into Family Violence and national Royal Commission into Institutional Responses to Child Sexual Abuse are both likely to identify significant unmet need for mental health support. The CMMHS sector is well placed to respond to those needs that will not be met by the NDIS. A state mental health response cannot only rely on expensive and scarce acute mental health services. The non-government sector is able to deliver innovative and cost effective services that effectively respond to the needs of people who have experienced family violence or sexual abuse.



The NDIS is the most significant change to disability support, including psychosocial disability, in Australia's history.

Perhaps one of the greatest gaps that the introduction of NDIS will expose will be the provision of support to families and carers. While the NDIS will provide support to families as identified through individual recovery plans, little will be available to families if the person with the disability does not want to allocate funding support, or to help meet the individual needs of carers.

Victoria is reliant on the millions of hours of support that families and carers provide at no cost to the community. While this support is not provided with the expectation of reward, it is reasonable for families and carers to expect that there is a system of support designed to meet their needs as well. Also, there is substantial evidence that carers themselves experience mental health issues as a consequence of the burden of caring. Without the support currently available through community managed mental health services, the cost to the health system will increase.

The opportunity and challenge for the traditional CMMHS sector will be to develop more integrated service offerings and diversify their funding streams. The 2014 final report of the National Mental

Health Commission's National Review of Mental Health Programmes and Services highlighted the siloed nature of service delivery and support systems (National Mental Health Commission, 2014). Consumers, families and carers and bureaucrats will be looking for more integrated service responses which can deliver across the domains of recovery, treatment, physical health, and social and economic participation. The NDIS, in its first three years, will increase the focus on psychosocial disability and service providers will be distracted by the complexity of responding to the changes in service offerings and demand, which will be a consequence of the scheme.

It is critical that the Victorian Government continues to invest in community managed mental health services for those people who will not be supported through the NDIS, or who are requiring mental health care. Not do so will not only leave large service gaps for vulnerable people; it will increase the burden on costly acute services and will risk Victoria's reputation as a leader in community mental health throughout Australia and across the world.

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The 50% challenge – embracing the consumer workforce



Indigo Daya is General Manager, Consumer and Carer Leadership and Advocacy, at MI Fellowship

At The Mental Health Services (TheMHS) conference in 2013, keynote speaker and world leading recovery academic, Professor Mike Slade, put a challenge to our sector: he said that 50 per cent of the mental health workforce should be comprised of consumers. I spontaneously applauded, naturally, but many did not.

The mental health sector is undergoing its greatest rate and scale of change since deinstitutionalisation. Entire service streams such as rehabilitation are at real risk of disappearing, new disability supports are here, and new strategies, outcomes and research seem to rain down on us faster than prime ministerial challenges.

In the midst of this change, the sector is still attempting to come to grips with the concepts of peer work and the consumer workforce, and around fundamental questions, such as: What is the consumer workforce, really? How does it fit into the rest of the mental health sector? How does it contribute to better outcomes? Is it really needed, or is it just political correctness?

And yet, while these fundamental questions remain blurry for many, the big picture is at risk of being lost amidst all this change: clarity about the essential and integral role of the consumer workforce in the overall mental health sector's ability to enable genuine recovery for consumers.

The challenge

It is no surprise that many would struggle with the scope of Professor Slade's challenge. For all that the consumer workforce brings and promises (and this is a great deal), many struggle to see how the consumer workforce fits into existing paradigms.

Some see it as a threat to job security, existing power structures and respect for professional skillsets, while others see it as purely tokenistic.

This tokenism is often true, incidentally, but this does not speak to the value of consumer workers, but instead about the way our roles are understood, implemented and supported.

Some speak about having witnessed unhelpful or even harmful peer work practice, and express concern about its usefulness or relevance. Of course, any worker may exhibit harmful or unhelpful practice, and peer workers are no different in that respect. The lack of systemic and accessible training, clear job roles, adequate support and supervision and inclusive workplaces are areas that must be addressed here.

So, what would a 50 per cent peer workforce bring, and how would we do it?

Not just about health

One reason to argue for a stronger, more embedded consumer workforce is because mental health is not, by any means, just about health.

Mental health is the one part of the health system that is governed by legislation that encroaches on the international human rights of the people it serves. This fact alone makes the mental health system different. It means that our work can never be just about health, but it is also inherently political, rich with complex ethical dilemmas, and it serves a group of people who largely experience profound social, economic and health disadvantage and discrimination.



As much as no-one likes it, the indisputable fact remains that for a great many consumers, the mental health system can do more harm than good.

Where any social group has experienced disadvantage and discrimination, we have, as a society, come to see the integral importance of that group taking a strong role for their own empowerment. Women led the suffragette movement. Blacks led the American civil rights movement. People who identify as GLBTIQ lead the gay pride movement. And in the same way, mental health consumers must, and increasingly do, transform the health and social structures that perpetuate disadvantage and discrimination for us. Of course, none of these movements existed in isolation. Men, whites and straight-identifying people have joined all of these other civil rights changes, just as non-consumers are part of the changes in mental health. Allies are essential.

Failure of research and systems

Another reason for the central involvement of the consumer workforce is shifting views about the nature of mental health problems and recovery towards more social models of health. Ideas from recent decades about chemical imbalances being the cause of mental illness have been effectively discredited and it is now well accepted that mental health problems are a complex interplay of social, biological and psychological factors. The enormously high prevalence of trauma is indisputable, and a good example of this interplay. Further, we now understand that people can lead great lives of their own choosing, whether or not they experience 'symptoms' of 'mental illness' (Pies, 2014; Hickey, 2014; Fisher, 2013).

We must also acknowledge the flood of consumer stories of recovery, where people speak of recovering 'in spite of mental health services'. This tells us a great deal. We need to listen to these stories, but more importantly, we need to learn from them.

And finally, as much as no-one likes it, the indisputable fact remains that for a great many consumers, the mental health system can do more harm than good. Forced treatment, restrictive practice, messages of hopelessness, 'realistic' goals, discrimination and even violence perpetrated within services – these all combine to create a system which does indeed require reform. And this is not to mention the role that forced medication plays in reducing life expectancy, or

that electroconvulsive therapy plays in stripping memories and a sense of mental integrity. Some may argue that community services work outside of these paradigms of harm – and yet all parts of the mental health sector are interconnected. A problem in one part is a problem for all.

So, if mental health is about politics and ethics as well as health, and it's about complex social and psychological factors as well as about biology, and it is trying to help more than it currently hurts, then it is clear that:

- a. health and community professionals require far more complex and diverse training and practice
- b. we need to radically rethink systems and structures, and
- c. the people who this system exists to serve just might have something to say about that.

Recovery basics

The fundamental, most important question, must be: does the consumer workforce contribute to recovery? That is, after all, why we are all here.

The evidence tells us that this is certainly the case. Key peer work benefits identified in the research that were summarised by Health Workforce Australia (2014) include:

- Reduction in hospital readmissions and improved discharge rates (see Chinman, Weingarten, Stayner & Davidson, 2001; Forchuk, Martin, Chan & Jensen, 2005)
- Increased sense of independence and empowerment, which may have related to increased stability of work (see Repper & Cater, 2011; Ochocka, Nelson, Janxen & Trainer, 2006; Campbell & Leaver, 2003)
- Higher levels of community integration, improved social support, enhanced social skills and improve social functioning (see Repper & Carter, 2011; Forchuk, Martin, Chan & Jensen, 2005)

Our work can never be just about health, but it is also inherently political, rich with complex ethical dilemmas, and it serves a group of people who largely experience profound social, economic and health disadvantage and discrimination.

- Altered attitudes to mental illness, breaking down stigma and fostering hope (see Mowbray, Moxley & Collins, 1998; Repper & Carter, 2012; Stratford, Brophy & Castle, 2012)
- A Cochrane review found that 'in delivering the same functions and activities, peer support workers produced outcomes comparable with their non-peer colleagues' (see Pitt et al, 2013).

Further, the consumer workforce offers benefits for mental health services and the broader system:

- Establishing connections with 'hard to reach' clients (see Sells, Davison, Jewell, Falzer & Rowe, 2006)
- Acting as a bridge between clients and staff (see Davidson, Bellamy, Guy & Miller, 2012)
- Enhancing overall staff commitment to recovery (see Bradstreet & Pratt, 2010; O'Hagan, 2011)
- Educating non-peer professionals about the experience of living with mental health problems, contributing to empathy and understanding (see Walker & Bryant, 2013)
- Peer workers may assist in reducing coercive mental health practice and changing staff attitudes towards seclusion and restraint (see Ashcraft & Anthony, 2008).

Who is the consumer workforce?

A lot of language gets thrown around in this space: peers, lived experience, consumers... what does it mean for the workforce? Here are some clarifications, although it should be noted that much of the language in this space is contested:

1. Lived experience is increasingly used as a term which embraces both consumer and/or carer experiences.
2. Lived experience of consumers generally refers to:
 - a. mental health problems/madness
 - b. mental health service system use/consumers/survivors/ex-patients
 - c. recovery (personally defined)
 - d. social exclusion, disenfranchisement, trauma and more.
3. Peer work is an emerging discipline and practice rather than a specific type of role. Some literature refers to peer workers as being distinct from professional roles. This is generally an unhelpful distinction. It is more helpful to speak about 'peer' and 'non-peer' professionals.
4. For consumers, peer work is closely tied to the consumer human rights movement, and to the growing discipline of madness studies. Consumers may be peer workers for other consumers, while carers may be peer workers for other carers. To be a peer worker, a person generally requires:
 - a. lived experience as outlined above
 - b. training or experience in the discipline of peer work
 - c. willingness to disclose and to intentionally and purposefully use their own lived experience in the role.
5. The consumer workforce is utilised in a wide range of roles and responsibilities, as shown in table 1, and this scope is expanding to include every level and aspect of the mental health service system.

It is the job of the consumer workforce to continue to develop its own models of practice, research base and professional codes. However it is the responsibility of the sector as a whole to be enabling of these processes, and to recognise and respond to breaking down the inherent systemic barriers faced by this growing, valuable, but still often disadvantaged group.

While the mental health consumer workforce is still relatively new, it faces similar challenges to any other previously excluded social group that is seeking equity, such as when women began entering the workforce in large numbers.

Table 1: Consumer workforce roles and responsibilities

Consumer role types	Consumer role categories	Consumer role examples
Service delivery	Peer work within existing service delivery models Consumer-developed models/programs Consumers as 'engagers & guides' Consumers as 'another strand to a multidisciplinary work team' Consumers as 'experts in peer practice'	Consumer buddies Consumer mentors Peer system navigators, peer guides Peer intake workers Peer support workers Peer group facilitators Peer crisis support workers Peer discharge support workers Peer specialists (eg consumer models such as hearing voices approach) Peer supervision (eg includes supervision for peer workers and also supervision with a consumer perspective for non-peers)
Advocacy & change	Individual advocacy Systemic advocacy Political action	Consumer consultants Consumer advocates Consumer activists
Learning & knowledge production	Academia Higher education Vocational learning Public education	Speakers bureau roles Consumer vocational trainers Consumer tutors and lecturers Consumer writers Consumer academics and researchers
Organisational operations, management, governance & sector design	Operational management Organisational and sector strategy Policy design and implementation	Consumer executives and managers Consumer supervisors Consumer policy workers Consumer advisers Consumer board directors Consultants
Participation	Organisation/service delivery feedback Service delivery process improvement	Consumer representatives Consumer committee members Expert reference group members
Ownership	Consumer-led enterprise	Range of roles in consumer-owned and run enterprises Peer projects Consumer led community development

A lack of understanding by the sector often translates into consumer roles not being set up to succeed, and consequentially reinforcing unhelpful, discriminatory views.

While the mental health consumer workforce is still relatively new, it faces similar challenges to any other previously excluded social group that is seeking equity, such as when women began entering the workforce in large numbers. Consumer roles still tend to be at entry level pay grades, roles tend to be casual or part-time, rates of pay are not always in parity with other professionals, reasonable adjustments are challenged, and appropriate professional supports are not always provided. A lack of understanding by the sector often translates into consumer roles not being set up to succeed, and consequently reinforcing unhelpful, discriminatory views.

To address this requires sector support – in practice and in funding – for the continued professional development of the consumer workforce and peer work by consumers themselves. It also needs organisations that will better grapple with structural barriers to the changes brought by the consumer workforce, and embrace a shared responsibility for changing these structures, rather than locating issues within individual consumer workers.

Another important question yet to be answered by the consumer movement and consumer workforce, is whether, and if so how, consumers may begin to intentionally use lived experience and the peer work discipline within more traditional mental health sector roles. Could, for example, a nurse who is also a consumer intentionally apply peer work practice to a role? And if so, what would this mean in the context of involuntary treatment?

It is helpful to remember that peer work is an emerging discipline, rather than a specific type of job role. In the way that other disciplines bring a particular perspective or framework to their work (for example, a social worker and a psychologist are likely to see a similar issue from different perspectives), so too does peer work. Peers draw on:

- lived experience
- processes of mutuality and reciprocity
- naming and breaking down power
- creating different paradigms to roles like 'helpers' and 'recipients of help'.

Like other disciplines in their early emergence, the practice models and research for peer work is flourishing and in a state of flux.

What is peer work?

Mead (2001) states: *Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships.*

Key aspects to remember about peer work are that it:

- is an emerging practice and profession that responds to the innate human need for connectedness, relatedness and equality, and has always existed informally
- values the wisdom of related and collective lived experience while also respecting the diversity and strength of individual difference
- aims to build transformational relationships of reciprocity which challenge traditional notions of expertise and power
- frequently occurs amongst groups of people where human rights are a systemic issue and strives to uphold and advocate for these rights
- frequently occurs amongst groups of people whose collective types of experiences are stigmatised and/or excluded from wider discourses
- is different from other 'helping' professions in that it is:
 - » not about 'helping' but about enabling empowerment and facilitating self-determination
 - » not about creating or imposing professional recommendations, meanings and language frameworks onto people's experience, but seeks to understand and relate to people's own language, meaning and capacity for growth
 - » usually carried out with a more flexible set of boundaries which enable interpersonal sharing and connection, and is
 - » innately and unwaveringly hopeful.



The particular risk for the consumer workforce is being seen as a low-paid alternative to non-peer professionals.

Growing the consumer workforce

While some organisations have developed great expertise in peer work and growing the consumer workforce, others are still coming to grips with fundamental concepts.

Some key factors worth considering in organisations are:

1. Peer work is an emerging discipline, so organisations need to keep informed of emerging principles, practices and evidence, and ensure peer worker training is kept up to date and supervision is appropriately skilled.
2. The implementation of peer work must be led by people with expertise in peer work. A common mistake by organisations is to use people with expertise in other disciplines to establish peer work programs, and then subsequently fail to incorporate core principles of peer work into the organisation or practice models. An analogy would be to employ doctors to establish a nursing program. This practice also fails to respect some of the fundamental principles of peer work practice, which are empowerment, self determination, and 'nothing about us without us'.
3. All consumer workers must be able to access supervision from experienced peer work specialists. This may be separate to managerial supervision if the peer worker's manager or team leader is not a peer. This ensures that peer workers can access professional support and guidance for how to apply peer work practice to their role. A common problem that can occur without appropriately skilled supervision is a misunderstanding of when, how and why peer workers share their personal experience. For most other professions this peer work practice would be considered a boundary violation, while for peers it is fundamentally essential.
4. Having lived experience of mental health problems is insufficient to be a peer worker. Peer workers also need a lived experience of self-determined recovery and adequate training in the discipline of peer work suitable to the role. Non-peer workers with a lived experience should be able to access other ways of contributing their lived experience if they choose to do so.

5. Consumer workers, like all other workers, have the right to reasonable adjustment by their employer. Reasonable is the key here, and it must be balanced with the risk of tokenism. Peer workers should be expected to carry out similar workloads and achieve similar outcomes to non-peer workers once reasonable adjustments are taken into account.

6. Many organisations are concerned about the wellbeing of peer workers. This is fair but cannot be addressed in ways which are discriminatory, or which locate issues with the individual rather than taking a systems view, or which confuse issues of practice with issues of wellbeing.

Wellbeing is an issue for all workers, not just peer workers. Mental health workers in general have high levels of stress and burnout, and have at least as high a prevalence of mental health problems as the general public (about 20 per cent in any year) (Australian Bureau of Statistics, 2007). Good wellbeing programs are voluntary, private, involve choice and respect the dignity of workers.

When organisations focus on just the wellbeing of peer workers they risk several issues. The first, and most important, is being discriminatory, but there are further issues:

- They may be reinforcing stereotypes that peer workers cannot cope. This can create problematic attitudes and cultures in the broader workforce.
- They may fail to recognise that many peer workers will have developed more skilled wellbeing strategies than their non-peer colleagues, as part of their recovery journey – and so this approach could be seen as inherently disrespectful.
- These programs often focus on how individuals should take responsibility for their wellbeing, rather than acknowledging systems issues which impact wellbeing. This approach locates the problem in the person, rather than seeing that the problem is everyone's business. A systems approach will instead look at how the organisation as a whole promotes and enables wellbeing, and how the organisation is flexible enough to adapt to individual needs.

I'd suggest we are likely to see a growth in boutique consumer-owned providers.

- Wellbeing programs can potentially confuse peer work practice with worker wellbeing. If a wellbeing program starts to talk about use of lived experience in the role and it is not delivered by an expert peer worker, then it has crossed over to become practice training. There is a risk of giving conflicting messages about good peer work practice. Supporting peer workers to understand how, when, where and why to share their lived experience is a central part of any good course in peer worker training – not a feature of a wellbeing program.

Risks and opportunities with reforms

Recent mental health reports and strategic papers have all highlighted the imperative of building the lived experience workforce:

'Peer support workers are a key component of recovery-oriented mental health services as they illustrate to others the possibility of recovery and participation in social and employment activities, and provide support for their own recovery. Increasing the number of peer workers in mental health services nationally is an immediate priority....'
(National Mental Health Commission, 2014).

'Develop and support the lived experience workforce, with an initial focus on growing the paid lived experience workforce, and supporting the professional development of this workforce through clear and consistent role descriptions, supervision and career progression.'
(Victorian Government, 2015).

It remains to be seen how these recommendations will translate into policy, however we are likely to see increased targets for the employment of the consumer workforce. The National Mental Health Commission has developed course materials for the accredited Certificate IV in Mental Health Peer Work, however greater investment is required in funding actual training places, not to mention increasing available positions.

Structurally, we are sorely in need of two other areas recommended by the Commission:

- national mental health peer workforce development guidelines
- national mental health peer workforce data set, data collection and public reporting approach across the sector.

Health Workforce Australia (HWA) completed an important initial body of work in defining the peer workforce, which provides a foundation for further work. It is essential that these strategic priorities are led by consumers with expertise in peer work.

And what about on the ground?

The Victorian community-managed mental health sector has been a strong supporter and employer of the consumer workforce – primarily through the Mental Health Community Support Services (MHCSS), Personal Helpers and Mentors Service (PHaMs) and Mutual Support Self-Help (MSSH) funding streams.

As the sector moves towards the NDIS as its new, primary source of funding there are risks and opportunities for the consumer workforce. First among these are the much lower hourly rates paid by the NDIS for support work, estimated to be between 40% to 50% of the rates paid through existing funding models. This will impact the pay grades for the entire community workforce and is a major risk for the whole sector. The particular risk for the consumer workforce is being seen as a low-paid alternative to non-peer professionals. While it may be appropriate for some lower skill consumer roles to be paid at lower levels, rates must always be based on skill, and requirements of the role, like any other. However, given the low employment rates of consumers in general, there remains the potential for exploiting a vulnerable workforce.

An important opportunity with the NDIS is that participants can choose their preferred service provider and supports. For those who prefer peer support, this has the potential to increase demand for employing the consumer workforce. The design of the scheme makes it far more accessible for consumers to provide their own consumer-delivered services, either as sole providers or to create their own enterprises. I'd suggest we are likely to see a growth in boutique consumer-owned providers.

Utilisation of the consumer workforce within the clinical sector has been patchy. While consumer consultants are generally embedded into hospital-based services, the use of peer support workers and consumer specialists is highly variable. The National Mental Health Commission has recommended that every person being discharged from hospital should be offered the support of a peer worker, and this seems a sensible place to start.

Where to from here?

There are lots of immediate concerns to address with the consumer workforce. But we must also understand and embrace the strategic considerations of the consumer workforce as the sector is continually reshaped through these reforms.

This requires us to think about consumer roles in three dimensions. We must look horizontally across all types of service delivery, and vertically across all levels. We must also look into the system and ensure there is space for new, consumer-led models of practice to emerge and be nurtured. And wrapping around all of these considerations, we sorely need national and state effort, co-produced with consumers, to lead peer work practice, standards, workforce development, and measures.

We should, indeed, work towards the idea of 50 per cent of the workforce – but we have a lot of work to get it right.

At a recent consumer forum, we were asked to consider the question, *'what could be a measure of the consumer workforce getting to where it*

needs to be?'. One response stuck with me: *'We would be there when no-one is the least bit surprised at the idea that a consumer could be the clinical director of a mental health service.'* Everyone laughed, because today that concept is almost unimaginable. But then we wondered, really, why couldn't this be the case? We're not there yet, but we could be on the way.

At the end of the day, as we think about the rapidly changing mental health landscape, we come back again to the key driver: recovery. Processes of empowerment, hope and meaning are central to what changes people's lives – not specific treatments or 'SMART' goals. And almost every strategic review of mental health strategy has come to a similar conclusion about this subject: if we are to truly enable these recovery processes to occur, then we do indeed need substantial redesign of current systems, structures and approaches, and deep cultural change across the sector. The consumer workforce is particularly effective at processes of building hope, empowerment, meaning and more. The more we grow and strengthen this workforce, the more we will necessarily embed real cultural change.

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Innovation and rehabilitation in Victorian mental health



Alan Murnane is General Manager, Primary and Mental Health at Inner South Community Health

‘The overall impact of a poorly planned and badly integrated system is a massive drain on peoples’ wellbeing and participation in the community – on jobs, on families, and on Australia’s productivity and economic growth.’ National Review of Mental Health Programmes and Services (2014) Summary.

What are the implications from the ‘poorly planned and badly integrated system’ for people with mental illness and for the Victorian Mental Health Community Support Service (MHCSS) sector amid an array of reforms leading up to the roll-out of the National Disability Insurance Scheme (NDIS)?

This is a vital question given that the National Review could not evaluate state and territory-funded programmes, services and systems. In addition, the Victorian MHCSS has recently been recommissioned, so data and evaluation is yet to be significant.

Identifying and understanding the strengths of the existing system can inform the development of an improved system. This article will focus on the value to consumers of a funding regime that ensures availability of funds for service innovation and improvement over and above that required to provide direct service. It outlines two initiatives of Inner South Community Health (ISCH) demonstrating the value of funding that allows service development.

I. ISCH/Alfred Health Community Psychiatry Clinic

The ISCH/Alfred Health Community Psychiatry Clinic is a low-cost, high-impact initiative that is funded through the Medicare Benefits Schedule (MBS). Established in 2009, it comprised a weekly four-hour session at ISCH and demonstrates excellent outcomes.

Its aims are:

- To provide a pathway from specialist clinical services at Alfred Health to highly-accessible community-based universal services based on a shared care model between clinical psychiatry, community health and GPs.
- To provide people living with major mental illness the opportunity to maintain mental health and sustain independence in their community, while receiving appropriate specialist psychiatric care in an integrated primary health care environment.

Its objectives are:

- To reduce demand on specific clinical services in the ISCH catchment.
- To provide a more appropriate service response to clients who have a major mental illness but have the capacity to have their treatment managed in the community.

The original target group was clients experiencing severe mental illness and psychiatric disability, and active in both ISCH mental health services and Alfred Psychiatry.

The initial goal was to transfer the support of a group of Alfred clients from a clinical setting to the community mental health services at ISCH.



The clinic has demonstrated that, with the right treatment and support, people living with major mental illness can maintain mental health and sustain independence in their community, subject to receiving appropriate specialist psychiatric care.

The initial outcomes data for the initiative was so successful that the goal was broadened to include:

- Clients of Alfred Psychiatry; transferring them to ISCH mental health services to be included in the new initiative, subject to eligibility.
- ISCHS Mental Health Services clients who require psychiatric assessment or review; eliminating the need to be referred to clinical services.

The key drivers for the clinic initiative were demand management and client-centred care.

There is extensive evidence on the impact of deinstitutionalisation on people living with major mental illness. Our model responds to this literature and the lived experience of consumers, carers and mental health personnel, in particular to:

- The adverse impact of poor service coordination/integration, particularly the lack of opportunities to 'step up' and 'step down' from services according to need. In some instances, this is due to lack of services, but often the underlying cause is the absence of formal pathways.
- The 'lived reality' of community-based clinical care that is provided by hospitals or in hospitals rather than community settings. It often fails to integrate sufficiently with other services that people require to live independently in the community.
- The capacity of community-based care to improve engagement with other aspects of wellbeing.

Key stakeholders with whom the ISCH Mental Health and Alfred Psychiatry teams engaged were:

- GPs in the ISCH catchment. Without GPs to provide treatment and manage medication prescribed by the community psychiatry clinic, the clinical-community pathway cannot be established. Whilst most GPs would have a level of exposure to clients with serious mental illness, some require support developing expertise in therapies such as clozapine. ISCH was able to leverage its local networks to establish GP relationships for all clients.
- Other ISCH community health programs, in order to realise the full value of transitioning clients to a primary health care environment (e.g. dentistry, allied health such as podiatry, alcohol and drug services, and financial counseling).

Benefits

The clinic has demonstrated that with the right treatment and support, people living with major mental illness can maintain mental health and sustain independence in their community, subject to receiving appropriate specialist psychiatric care.

The benefits for consumers in 'stepping down' to community-based care include:

- reduced stigma
- increased community engagement
- shift in focus to rehabilitation and recovery
- provided a foundation to address other (often neglected) aspects of wellbeing, including physical health.

The benefits for the system included alleviating pressure on clinical services in the region.

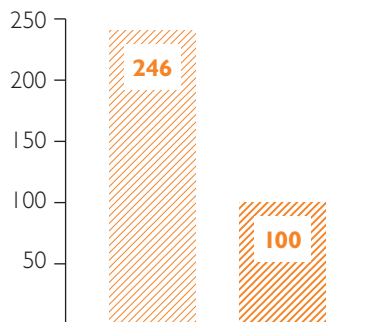
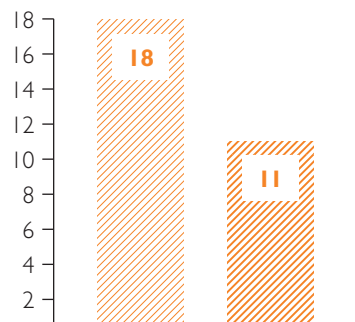
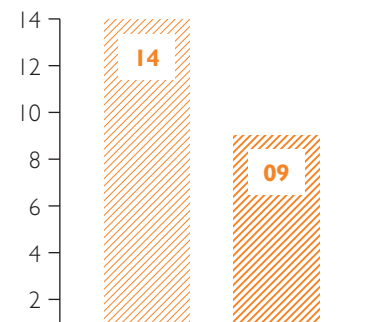
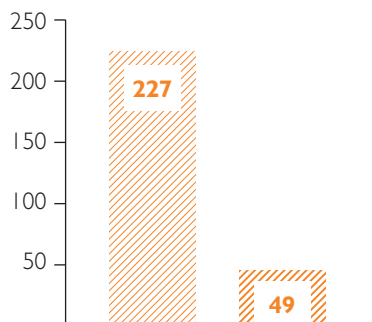
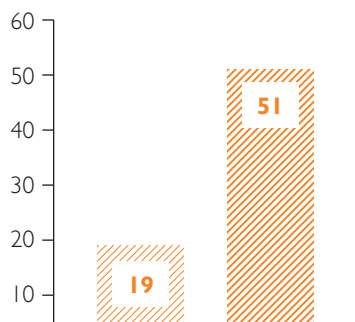
Outcomes data

A review of the 50 clients using the clinic over a one year period revealed:

- 100 per cent of clients were successfully maintaining a relationship with a prescribing GP.
- 76 per cent were accessing at least one ISCH primary health care service other than mental health (and 42 per cent were accessing three or more).
- Demand for bed-based clinical services was significantly reduced in the very first year of the initiative, with data showing clients using 60 per cent fewer bed-days. Significantly, bed day usage was increasingly being diverted from acute to recovery-focused sub-acute care, indicating clients were not as unwell even when they required bed days. Acute bed days usage dropped from 227 days to 49 days, while use of the less intensive sub-acute bed days (and lower system cost) only increased from 19 to 51 days.

The findings of this small study (opposite) are in line with the national Mental Health Review proposal for 'building up those services which prevent hospitalisation or enable people to be discharged earlier from hospitals into community based care' (National Mental Health Commission, 2015).

Outcomes data

01 Total psychiatric care bed days
(acute and sub-acute)**02** Average length
of stay-days**03** Psychiatric
admissions**04** Bed days in
acute services**05** Bed days in
sub-acute services

Year prior to
starting the clinic

One year
after the clinic

2. Engagement with the Aboriginal and Torres Strait Islander community

The delivery of culturally appropriate services to the Aboriginal and Torres Strait Islander community is a priority for ISCH and is a focus of our mental health service.

Working to ensure the Aboriginal and Torres Strait Islander community has equal access to mental health services, ISCH takes a proactive and sustained approach to build trust and engagement. This requires a commitment of resources that does not easily align with traditional

mental health service approaches which are focused on an individual. It requires long term commitment in relationship building from services, and reciprocal engagement from the Indigenous community once trust is developed.

Strategies for engagement include:

1. Fortnightly gathering led by local Aboriginal and Torres Strait Islander community members at Our Rainbow Place, an Indigenous meeting place within an ISCH site.



Working to ensure the Aboriginal and Torres Strait Islander community has equal access to mental health services... requires long term commitment in relationship building from services, and reciprocal engagement from the Indigenous community once trust is developed.

2. Weekly engagement at Womin Jeka, a community meeting of the Indigenous community to build links and trust that allows introduction of mental health staff to community members.
3. Co-facilitation of an Indigenous women's group with a local Indigenous service.
4. Understanding of the barriers for Aboriginal and Torres Strait Islander clients in accessing traditional mental health services. This requires 'marrying' of the Indigenous perspectives on health and community with the mental health way of working. Examples of this include:
 - » acknowledgement of a much broader view of family
 - » use of the term 'outreach' for the service rather than 'mental health'
 - » commencing work without requiring clients to be registered clients of the service
 - » support of and engagement in National Aboriginal and Islander Day Observance Committee (NAIDOC) week events every year
 - » Indigenous cultural awareness training for all mental health and alcohol and drug staff
 - » provision of 'Dental As Anything', an assertive dental outreach service that works to identify and engage hard-to-reach members of the community and to provide dental consultation in diverse and unconventional settings (Burchell et al., 2006)
 - » development of respectful and robust relationships with Aboriginal and Torres Strait Islander Elders, within programs, management and the governing body of ISCH.

Outcomes

An audit in 2013 in preparation for the recommissioning revealed ISCH had more than 40 registered Aboriginal and Torres Strait Islander clients across mental health and alcohol and drugs services, drawn from an estimated community of 480 Indigenous people living in the City of Port Philip and Stonnington region. In addition, staff were engaging with many other Aboriginal and Torres Strait Islander people who were not yet registered as clients.

Summary

The innovative outcomes within these two initiatives was facilitated by:

- an organisational culture that supports and encourages innovation
- a mental health team seeking excellence
- unit funding within State funded Psychiatric Disability and Rehabilitation Support Services (PDRSS) sufficient to support qualitative and innovative projects alongside service delivery
- cooperation and coordination between service providers.

The future challenge for innovation looms large.

As mental health service provision moves to a competitive service environment under the National Disability Support Service (NDIS), adequate levels of funding (NDIS and State), as well as inter-agency and inter-government cooperation, will be vital to ensuring the service system continues to improve advocacy and support for mental health consumers and their families.

Anything less could only be described as system failure.

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Differentiating holistic mental health care from disability care



Arthur Papakotsias is the CEO of Neami National
Glen Tobias, Victorian State Manager at Neami National

With the approaching roll-out of the National Disability Insurance Scheme (NDIS) there is considerable concern about the types of services currently being provided to consumers and carers by the non-government mental health sector and what will be available under the NDIS.

From information gathered through numerous consultation, review and scoping projects conducted to date, it appears the NDIS will not neatly replace all of the service components that are currently delivered by the non-government mental health sector. It also continues to be unclear whether any services will be provided to complement the NDIS offering and, if so, how they will be funded.

What seems to have been overlooked with the inclusion of mental health in the NDIS is that the overwhelming majority of consumers who use mental health services do not stay forever.

On the contrary, they move through the system because they gain skills, confidence, and self-esteem. In other words they **recover** to the point that they no longer need mental health services. In fact, the default position of holistic mental health services is to *expect recovery to occur for consumers* rather than expecting to support people all their life. Of course, recovery is a very individual process and there are some people who continue to need support over many years and others who move in and out of the system as their needs change.

This article attempts to describe a holistic mental health care system and how disability care is a component of this care. One way to highlight what constitutes holistic care is to describe a consumer's journey through the system, dividing the journey into a beginning, middle and an end.

The beginning

The critical component of holistic mental health care is beginning well. This is underpinned with an assumption that great things are possible through relationships that are 'real'. The staff member is truly interested in the consumer as a person and is hopeful that growth and recovery can occur even when the consumer is not. It is a two-way engagement process requiring the development of a therapeutic, interactive and trusting relationship.

Holistic mental health care does not begin with the question, 'What is the problem?' Rather, it begins with an exploration of a consumer's values and beliefs. What is important to them, what do they hold near and dear to their hearts? How will our work together be best achieved? What are their existing strengths and abilities and what can be built upon?

To inform the development of the Individual Plan and to help identify the supports required, the consumer is invited to complete evidence-based tools and protocols, such as needs assessments, outcome measures, substance use assessments and physical health prompts. A risk assessment and risk management plan is also developed as new information is gathered to inform and support the consumer and to ensure appropriate safeguarding plans are established.

The Key Worker coordinates the planning process with the consumer and their identified support networks, including the family/carer, clinical teams and other providers.



What seems to have been overlooked with the inclusion of mental health in the NDIS is that the overwhelming majority of consumers who use mental health services do not stay forever.

Services use a range of protocols to assist people to identify their individual journey of recovery. These tools assist consumers to identify their values and strengths, develop goals directed towards fulfilling their life vision and valued directions, develop a plan of action to achieve those goals and assist consumers to set an appropriate goal striving pace. Consumers and their Key Workers review the plan at regular intervals to assess progress toward the outcomes valued by the consumer.

To promote a relationship based on the key principles of recovery – hope and growth – the concept and possibility of exit is introduced at the beginning through an exploration of:

- What would a good exit look like?
- How would you know you were ready?
- What would you need to have achieved?

This approach highlights the difference in intention between disability support and a holistic mental health care service.

The middle

At the middle stage of the work there is a more sophisticated development where consumers increasingly take control of their lives. Staff exercise considerable judgment in their actions and approaches in working alongside consumers. This is a far more interactive process than the more transactional process of disability support.

Typically, holistic mental health care services use practice models that draw on evidence-based modalities including positive psychology, psychosocial rehabilitation principles, motivational interviewing and theories of change. These are consistent with person-centred planning models employed within mental health settings and focus on addressing individual needs and recovery.

The approach is designed to assist the consumer in their individual recovery journey through:

- bringing their values and strengths into focus
- building on the goals developed during the beginning phase to support them in moving closer to the things they value in life
- developing specific tasks and activities to support the achievement of personal goals.

The information gathered through a consumer-directed planning process is brought together and documented in the consumer's Individual Plan. The Individual Plan is used to direct the holistic mental health care for the consumer which is managed and coordinated by their Key Worker. The Key Worker focuses on a coaching process with consumers that assists them to take actions that will assist them with their goals.

Practical support which may appear at first glance to mirror disability support is also provided, however the 'intention' of these two activities is different. Disability support provides practical support as a means to the end, where the premise is on ameliorating the effect of disability. Holistic mental health care delivers practical support as a leverage to develop a trusting relationship, where coaching is the value-add towards the consumer's recovery goals. Importantly, support scales up and down in a dynamic way to adapt to consumer wellbeing and needs, rather than being set around task delivery.

Neami understands that it is often the delivery of practical support that enables clients to maintain their housing tenancy, address health issues of concern, navigate the income support system and develop strategies to meet their daily living needs. In turn, the delivery of these supports builds the initial trust, rapport and strong working alliance required to undertake the work. This strong collaborative working relationship is fundamental to Neami's recovery-oriented service approach.

Holistic mental health care is driven by a commitment to recovery and the values of self-determination, empowerment, diversity, choice and respect. As part of holistic mental health care, consumers are assisted to meaningfully participate in their communities and build connections with people and places important to them.

A recovery framework supports consumers to:

- build their resilience and strength to make choices about their recovery
- build their confidence while participating in their community of choice
- plan their own program and build connections with the community
- develop the skills and competence necessary to enjoy a full and rich quality of life
- work in partnership to enhance opportunities for citizenship
- stabilise their living situation.

Holistic mental health care is driven by a commitment to recovery and the values of self-determination, empowerment, diversity, choice and respect.

Formal processes are established to develop, sustain and review the coordination and communication of supports for consumers.

These processes include:

- allocating a Key Worker to each consumer, who will be responsible for the service coordination role and will be the primary point of contact
- ensuring that consumer data and notes are routinely entered on the consumer database to support detailed reporting and analysis
- taking a team-based approach in order to maintain the consumer's support when the Key Worker is on leave.
- holding daily consumer focused discussions, weekly team meetings, and fortnightly practice development sessions
- providing formal communication at key milestones for the consumer, including entry into the service, support needs planning, team review, exit planning and responding to relapse
- reporting, documenting and reviewing critical incidents within a safeguarding framework that communicates with senior staff and, where appropriate, with clinical teams, housing providers/other service providers, and others such as next of kin or carer/guardian
- developing informal and formal partnerships with relevant organisations to facilitate referrals and to coordinate care.

Ending

As consumers move towards exiting a service they will have developed clarity around what is important and valuable to them and will have identified the factors that would enable them to feel comfortable with exiting the service.

They will have meaningful activities to engage in and will have developed a sense of purpose. They will have established community and personal supports to ensure they are connected with their community. Importantly, they will have wellness and relapse prevention plans and understand how to link back to services if they require them.

At Neami we have long recognised that to provide quality recovery outcomes it is vital to invest in the development of a skilled and diverse workforce. Through focusing on competency and values-based recruitment and selection processes, we are able to supply a workforce that is strengths-focused and recovery-oriented. This is a critical foundation for the sophisticated level of skill development required to engage consumers in the coaching relationship and recovery journey. Over 70 per cent of direct service staff have a bachelor degree or higher.

Neami spends approximately 3 per cent of its staffing budget each year on staff development and training and recognises a clear link between this and the quality of the services provided.

An established learning and development framework sets out the training requirements associated for all positions and programs, including:

- a comprehensive induction program for all new direct care staff with further core modules specific to their role
- a core training program which includes the Collaborative Recovery Model, motivational interviewing, Applied Suicide Intervention Skills Training (ASIST), and integrated training on dealing with complexity and risk
- extension training for more experienced direct care staff in a speciality area of their choice, for example cognitive behavioural approaches, family sensitive practice and psycho-education
- in-house and external opportunities for staff as determined by organisational priorities and individual staff development plans
- training for key staff in the Optimal Health Program
- supervision and coaching training for all managers as a core element of their professional development program
- opportunities for staff to develop recognised industry experience, through the completion of Certificate IV in Mental Health, study leave and a scholarship fund.



Given the investment in workforce to deliver holistic mental health care, it is not accidental that consumers do recover to the point where they no longer need mental health services.

Neami has well established practices for support and supervision of staff. Line managers provide fortnightly supervision/practice development to coach and mentor staff in their direct support work with clients, and identify or discuss any learning and development needs. Fortnightly supervision is complemented by monthly team-based reflective practice. We undertake weekly case review opportunities to support both clinical management and staff learning.

Given the investment in workforce to deliver holistic mental health care, it is not accidental that consumers do recover to the point where they no longer need mental health services.

Conclusion

Neami's research over 15 years has shown that the greatest reduction in consumers' unmet needs occurs within the first two years of service. This timeframe roughly corresponds with how consumers move through the service: about 80 per cent stay for less than three years.

Our most recent data on more than 1,500 consumers shows that between 6 and 13 per cent remain engaged with holistic mental health care for more than five years. The percentage varies due to the range of programs and services provided over the five states. It is this cohort of consumers who are most likely to benefit from the disability support provided by the NDIS. However, for the vast majority of consumers, disability support will not replace their current experience of holistic mental health care and threatens to undermine the recovery outcomes that this support is clearly delivering.

A 10 Year Mental Health Strategy – VICSERV's response

It is imperative that the 10 year Mental Health Strategy include details on the transition process from MHCSS to NDIS and to the new state funded mental health service offering, as well as information on the pathways for consumers in and between these systems.

VICSERV applauds the Victorian Government's commitment to developing a 10 year Mental Health Strategy. We see this as a timely opportunity to consider the service delivery framework and contemporary service system model required for Victorians experiencing mental illness, and for families, carers, workers and services.

This is particularly so in the context of the implementation of the National Disability Insurance Scheme (NDIS) across Victoria over the next three years, and will provide the basis for Victoria's mental health service system for the future.

Victoria has been widely recognised as a leader in implementing progressive improvements to the treatment and support for people living with mental illness, their carers and families. This benchmark position must be retained and further developed.

We believe that the people of Victoria should not experience a loss of service standard and capacity as we navigate through the changing environment.

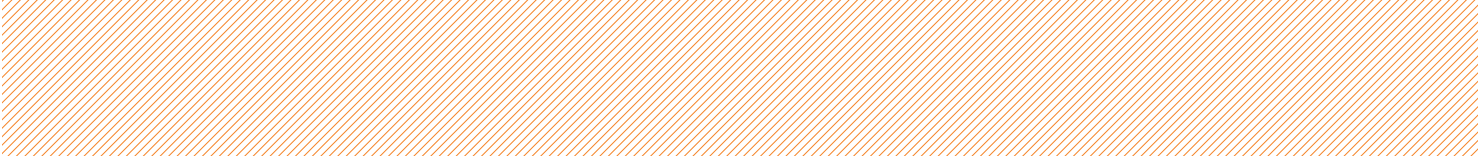
Building on our strengths

The Victorian Government has a strong platform from which to build a contemporary mental health system, including:

- an existing strong and effective community managed mental health support system
- the previous Labor Government's reform strategy, *Because Mental Health Matters*, which provides valuable policy and reform frameworks
- the *Victorian Mental Health Act 2014*, which, in conjunction with the Victorian Charter of Human Rights, provides a framework for the rights of people with mental illness and their right to autonomy and self-determination
- existing data and work on social determinants of health and indicators for mental health and well-being
- an extensive community support sector.

Welcome commitments

We support the Victorian Government's commitment to an 'integrated whole-of-government, whole-of-system effort' and the recognition that 'all levels of government, non-government organisations, the private sector, businesses and the wider community have a role to play' in achieving the vision and desired outcomes.



We also welcome the focus on prevention and early intervention to achieve broad community mental health and wellbeing, and to reduce mental health crises later in life – this focus should not however be restricted to childhood and youth.

Risks, gaps and concerns

In recent years the recommissioning of Psychiatric Disability Rehabilitation Support Services (PDRSS) and the introduction of the NDIS has resulted in significant disruption for consumers, families, workers and services across the State. A recent review of arrangements for delivery of Mental Health Community Support Services (MHCSS) and alcohol and drug treatment services found that the recommissioning has led to:

- a more siloed services system
- less availability of supports for people experiencing mental illness
- uncertainty for consumers, carers and families,
- less collaboration between services at the local level
- reduction in choice for consumers in the services, supports and treatment options available to them.

We are concerned that the move to MHCSS eligibility criteria of 'significant and enduring disability' has resulted in the exclusion of many who need assistance to maintain or improve their mental health.

At the moment there will be no psychosocial rehabilitation/MHCSS supports for people once the NDIS is rolled-out. While the Government has provided assurance of safeguards for people in the transition process, we have no indications of what the next iteration of the state funded mental health support system will be. Addressing this is a matter of urgency.

Despite the recent announcement of the implementation schedule for the NDIS across Victoria, there is still a lack of clarity around the support that will be provided to people with psychosocial disability. In this context, consumers, families and carers, workers and services need to know what supports will be available for consumers outside the NDIS.

The Discussion Paper identifies the intention to 'monitor any unintended service gaps or duplication that may arise as we transition to the new (NDIS) scheme and beyond.' In conjunction with continuous monitoring of the impacts of NDIS, there should be a commitment to address any gaps and ensure there is an effective state funded mental health service system, to which the NDIS system is a complement, from July 2016.

In light of this, and the range of current policy and service system developments impacting on mental health and connected community service areas, VICSERV urges the Victorian Government to commit to its role as systems manager.

In that capacity the State Government should monitor and act on emerging gaps under other service developments, and develop an understanding of how future changes will impact the delivery of services and people living with mental illness, their families and carers.

Summary of our recommendations

I. Vision and scope

VICSERV welcomes the State Government's commitment to developing a 10 Year Mental Health Strategy and the broad vision and scope presented in its Discussion Paper.

We welcome the focus on prevention and early intervention, the commitment to an 'integrated whole-of-government, whole-of-system effort', and urge that the Government commit to its role as systems manager to:

- monitor and act on emerging gaps under other service system developments
- articulate and develop an effective, contemporary mental health service system to which the National Disability Insurance Scheme (NDIS) is a complementary support system
- detail and support the transition process for consumers, carers, workers and services from MHCSS to NDIS and to the new state funded mental health service system.

VICSERV recommends the establishment of a mechanism, and potentially a Mental Health Commission, to oversee the governance and development of state funded Mental Health services, ensuring fidelity of the initiatives to vision and objectives.

2. Guiding principles

VICSERV endorses the identified guiding principles for the Strategy, particularly the inclusion of Co-production and Recovery Orientation, and recommends they incorporate:

- a human rights approach
- population health planning
- a life course approach
- social model of health that goes beyond just a focus on the social determinants of health
- adequate focus on all areas of diversity, with particular attention to culturally and linguistically diverse (CALD) communities.

3. Outcomes approach

VICSERV supports an outcomes approach and the regular reporting against the achievement of identified outcomes. We recommend:

- development of a comprehensive Mental Health Outcomes Framework, building on the work undertaken in *Because Mental Health Matters – Victorian Mental Health Reform Strategy 2009–19*
- expansion of the range of service delivery options and treatment options to ensure genuine choice for consumers
- enhancing the capacity of services and public mental health system for appropriate trauma-informed support and treatment, and reducing trauma for people with mental illness by providing least-restrictive, recovery-oriented and person-centred environments and approaches to treatment and care.

4. Development of a Service Planning Framework

The development of Victoria's next Mental Health Strategy provides a vital opportunity for the State Government to develop a world class mental health service system, and retain Victoria's standing as a leader in mental health care and support.

VICSERV recommends that the Government work with all stakeholders to develop a service planning framework that includes the key areas of:

- system structure and interfaces
- practice
- research
- workforce.

5. The importance of psychosocial rehabilitation

Specialist mental health rehabilitation falls outside the scope of the NDIS. VICSERV recommends that Victoria's Mental Health Strategy:

- identifies and acknowledges the important role of psychosocial rehabilitation in an effective, contemporary mental health service system
- includes psychosocial rehabilitation services as a component of the state funded mental health service system, alongside the treatment services of the acute assessment and treatment sector, and the disability support services of NDIS.

6. Leadership and systems change

In the past Ministerial Advisory Groups have successfully provided leadership and systems change, but are no longer in operation in Victoria.

VICSERV recommends the establishment of a mechanism, and potentially a Mental Health Commission, to oversee the governance and development of state funded Mental Health services, ensuring fidelity of the initiatives to vision and objectives.

7. Action plan for the Mental Health Strategy

VICSERV recommends a staged action plan for the Mental Health Strategy, with annual targets developed for the initial stage or stages, to be reported on each year to Parliament. Subsequent actions and targets should build on these initial stages, to create an iterative process of action, review and development.

newparadigm VOX POP

Respondents:

Jennifer Beveridge, Chief Executive Officer, Eating Disorders Victoria

Samantha Kolasa, State Manager – Victoria, Client Services, CareConnect

Sally Parnell, Acting CEO, Jesuit Social Services

Karenza Louis-Smith, Chief Executive Officer, Australian Community Support Organisation Inc.

Our *vox POP* asked CEOs and Senior Managers of a range of organisations for their views on the future of mental health support services in Victoria.

What do you think we can least afford to lose in the mental health system at this time of change?

Jennifer Beveridge

Peer support is a critical component to maintaining a sense of hope for recovery. Through the connections made by sharing and mutual support of one another, consumers and carers find ways to really engage with the services they need, not just access services. Let's keep funding for peer support.

Samantha Kolasa

For complex needs clients with mental health conditions which restrict their ability to engage and access systems like the NDIS assessment, it is important that there is a support system or process that facilitates their access to the NDIS funding and support. I think we run the real risk of people who are not deemed "disabled" or "unwell" enough for NDIS missing out on receiving a package and therefore supports.

Many of our consumers may not be able to articulate what supports they need or say that they don't need any when in fact they do need some. I fear these people will miss out on a service.

Sally Parnell

We need to fight for support for people with mental illness to be meaningfully engaged in community life and to be socially connected. A risk is that we focus on individuals in a simplistic way, and ignore the context of individual in community – and of the community change and community assets needed to better include people with mental illness.

Karenza Louis-Smith

The concept of catchment-based intake is a critical part of the new service system and its just starting to bed down. Having a global picture of wait lists, wait times and need ensures consumers won't fall through the gaps.

A stronger focus on the interface with community based mental health programs and drug treatment services is a critical piece of the jigsaw we still need to work on. A significant number of consumers are likely to need both – being able to join these up is an improvement we can continue to make.

What changes would you like to see to the current MHCSS system, if it or a similar system was retained?

Jennifer Beveridge

Abolishing catchment-restricted access to services would enable people to engage with services that **they** choose to provide their support and intervention. This would enable individual choice and person-centred care to facilitate real engagement with services, as Victorians embrace the principle of consumer choice.

Samantha Kolasa

I would like to see more social group-based activities. I would like people to understand that just being part of a group or spending time socially with other people who have mental health issues, is often enough to maintain people and keep them well. These people may not need any more support than feeling like they belong. A lot of the time mainstream groups/programs in the community still isolate or "don't fit" these people. I would like to see a focus on supporting people to support each other.

Sally Parnell

The current MHCSS has placed unrealistic barriers to service access, like the phone-based intake process and requirement to have a diagnosis, in the path of hard to engage people with mental illness, including young people. Intake needs to be more integrated with other programs, and a stronger focus placed on creating opportunities for social inclusion.

Karenza Louis-Smith

A stronger focus on the interface with community based mental health programs and drug treatment services is a critical piece of the jigsaw we still need to work on. A significant number of consumers are likely to need both – being able to join these up is an improvement we can continue to make.

Groundbreaking art studio closes after 20 years of creative recovery

newparadigm and its readers have benefited over many years and editions from cover artwork supplied by artists based at Neami National's Splash Art Studio in Melbourne's north. Unfortunately its doors have had to close in the wake of cuts to funding under the former State Coalition Government.

Creative expression of all kinds, and the visual arts in particular, play a vital role in recovery for many. Artistic practice can give life back meaning and magic while providing a sense of achievement and pride in creating something new and unique. For two decades a small art studio in Preston has been facilitating this process for hundreds of individuals from across Melbourne's northern suburbs.

Neami National's Splash Art Studio was created in the 1990s as a continuation of the in-house art program being run at Larundel-Mont Park prior to its closure. As people were moved out into the community via the de-institutionalisation process, efforts were also made to keep this creative outlet alive in the new world of community-based support.

What always set Splash apart was that it never operated as an art therapy program. It was staffed by a team of passionate and practising artists who worked with people on that level, not as support workers but as artistic peers who had the additional benefit of mental health training.

This transformative process enabled people to see that they were also artists and that they had talents and achievements – and did not have to be defined by their mental illness. Splash artists exhibited and sold their work in Victoria and across Australia.

The decision to close Splash in June 2015 was prompted by the former Victorian Coalition Government's recommissioning of the Victorian Mental Health Community Support Service (MHCSS) sector.

Neami self-funded Splash for a year after the funding ran out in order to give artists and staff some stability and to allow a supported transition. However, with no replacement funding available, the doors have had to close.

One of the last artists to exhibit at Splash was Carol Dobson, who was also a patient at Larundel-Mont Park before it closed. She said she was 'shocked' by the news. 'When you go to Splash you feel like you are not just "a person with mental illness". You are an artist.'

Another artist, Marnie Woods, said that 12 years of participating at Splash and receiving support from Neami helped her recover from the debilitating depression she experienced starting in high school. 'I know that coming here has really helped not just as an outlet, but also to help me to grow and use my art to do something that I never thought I would achieve. I'm very grateful.'

Neami National CEO Arthur Papakotsias paid credit to the proud and colourful legacy Splash will leave in the hearts and minds of people in Melbourne's north.

'Art plays an important part in recovery for many people, in both expressing the things they feel and experience, as well as in building their confidence and sense of self-worth. It is a sad day for everyone here at Neami, but we will continue to provide opportunities for consumers to link in with mainstream art groups and to find other ways to express themselves creatively.'



Psychiatric Disability Services
of Victoria (VICSERV)

Level 2, 22 Horne Street,
Elsternwick Victoria 3185 Australia
T 03 9519 7000 F 03 9519 7022
newparadigm@vicserv.org.au
www.vicserv.org.au

