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Editorial

Matt Clear
Editor

I’m pleased to be able to include a variety of voices on the issue of PARC services in this edition, including a number of powerful consumer stories and an important opinion piece.

Welcome to the latest issue of newparadigm. This edition is the first to be issued seasonally and you can look forward to receiving this quarterly journal in Summer, Autumn, Winter and Spring from now on.

Book-ending our work to map 21 years of psychosocial rehabilitation earlier in the year, I’m pleased to be publishing a piece by Val Gerrand that adds substantially to the thinking on the development of the sector.

We’re also printing letters to the editor that pick up on threads in our employment campaign and the issues we raised in our June issue of this journal as well as items covered in our September issue on mental health, housing and homelessness.

I welcome and encourage this form of dialogue in newparadigm. I want the journal to be a place where new ideas are shared and positions are questioned. It’s a place to discuss the developments in the sector and I’ll do what I can to foster and encourage debate within the sector in this forum. If you agree or disagree with anything you read – tell us!

This year we have worked hard to present material in newparadigm that tracks developments in the sector, but also to highlight work that is new and challenging. We’ve tried to highlight personal stories as well as organisational developments—we’re keen to tell your story and I encourage you to make contact with us to talk about possibilities for 2008.

With best wishes,

Matt Clear
Editor
Celebrating 21 Years of Psychosocial Rehabilitation

In this article, I would like to add a bit of history to what was reported in the March 2007 edition of new paradigm. Celebrating 21 Years of Psychosocial Rehabilitation.

Reclaiming our Past: Psychosocial Rehabilitation in Victoria

By Valerie Gerrard

Deinstitutionalisation

Turning first to ‘deinstitutionalisation’, the winding down of Victoria’s stand-alone psychiatric institutions was already underway by the 1960s. From 1963 to 1973, patient numbers were reduced by a third (Robson 2000:11). This trend continued, so that by 1986, ‘the number of inpatients at any one time is now less than 50 per cent of that in 1963’ (Office of Psychiatric Services 1987:8). The Willsmere Decommissioning Project (1986–88) then introduced a different approach to deinstitutionalisation. Willsmere was the first psychiatric institution to be completely closed in Australia, and this followed the establishment of alternatives, including inpatient, residential and community-based services (Rimmer, Buckingham et al. 1988).

This approach guided the downsizing and closure of the 14 remaining psychiatric institutions from 1994. Replacement facilities and services were well underway before institutions shut their doors. For example, the last institution to close in Victoria, Royal Park, was not shut until December 1999, after the new acute unit at the Alfred Hospital had started admitting patients. The Alfred unit was the last of the 13 Royal Park replacement facilities to open. From 1994 to 1999, when the institutions were progressively closed, the overall number of beds stayed relatively the same and since then has grown.

Kinkora remained a one-off for several years. From the 1960s however, early versions of the philosophy and practice of psychiatric rehabilitation drove developments in Victoria. In 1966 for instance, as well as outpatient psychiatric appointments, the services of Clarendon Clinic in East Melbourne included therapeutic groups run by the clinic’s social workers, an on-site OT industrial therapy workshop and a regular evening social club. The clients were former inpatients from psychiatric institutions at Bundoora, now living in the community. Another example is the Hoddle Unit, an inpatient rehabilitation unit established in 1968 by combining two medium-term wards in Larundel’s mental hospital. These are undeniably examples of rehabilitation services, even though the approaches lacked sophistication, resources were meagre and group programming predominated, instead of more individually tailored approaches. Nevertheless, the intent was rehabilitative: to prepare and support people in managing their own lives in the community.

Since then, rehabilitation services have continued to evolve. Above all, Victoria is noted for the development of its psychiatric disability rehabilitation and support services (PDRSS), which pioneered the use of psychosocial rehabilitation principles. By 1985, more than 12 psychosocial programs run by non-government organisations were already in place, including day programs like Halcyon and the Boomerang Club, and residential rehabilitation programs such as Denham House. There were marked differences between the states at that time. For example, rehabilitation services in New South Wales revolved around community-based ‘living skills centres’, which were government-run and largely staffed by allied health professionals. Often innovative in philosophy and practice, these centres were supported by regular statewide forums that enabled the exchange of ideas and experience (Weir and Rosen 1989). On the other hand, non-government provision of psychosocial programs was limited in NSW with the Sydney-based Psychiatric Rehabilitation Association (PRA) a notable exception. In South Australia, rehabilitation services were much more embryonic, with government-subsidised hostels the main feature. Hostel residents were bussed back daily to programs run on-site at the institutions. Unlike Victoria, neither NSW nor SA had a well-developed and expanding non-government sector providing psychosocial rehabilitation programs.

The history of Victoria’s PDRS sector is a major focus of this issue, however, and it is worth recording them here. They include Ken Patterson, chief social worker in Victoria’s Mental Health Division in the early 1980s, who secured initial state funding for the voluntary sector, as it was then called. This set a valuable precedent for the sector to receive government funding into the future.

Two other important figures are David White, Minister for Health in Victoria in the mid-1980s and Peter Worland, his Ministerial Advisor. It was Worland who convinced White firstly, that Willsmere could and should be closed, and that funding the establishment of VICSERV would mean there would be a ‘ginger group’ to advocate for mental health reform. White agreed to this move as it put pressure on his parliamentary colleagues to agree to the substantial upfront funding needed to provide replacement services before Willsmere closed (Gerrand 2005: 84). John Julian, the first Director of VICSERV, understood his job was to advocate for more funding and services. In the public sphere, he became a regular contributor to the letters’ sections of the Daily Press.
Securing adequate funding has been a constant thread through the history of PDRS. Two events were critical for the expansion of the PDRS sector over the period of major mental health reform in Victoria from 1994 to 1998. One was ensuring that Victoria’s PDRS sector got a guaranteed annual share of funding from the new 1993-98 Commonwealth-State Disability Agreement. This was successfully negotiated in the late 1980s and early 1990s with Disability Services, who had lead responsibility for the funding. In this instance, the key figures were Trevor Fleming, Sarah Goding and Kath Howlett.

Achieving a predictable 18 per cent of the CSDA funding in each of the five years of the Agreement, enabled forward planning for service development. This was especially important in housing and support, where a lead-time of up to two or three years was common before buildings were bought or constructed. In short, what is a little known internal government agreement, provided a critical base for the sector’s expansion throughout the 1990s and beyond. It was the envy of staff responsible for the PDRSS-equivalent in the other States and Territories, who had to battle each year for a portion of CSDA funding, so lacked capacity to plan ahead.

Lastly, in 1996, for the first time, Victoria’s then Psychiatric Services Division nominated a target for the PDRSS budget of 12 per cent of the adult mental health services budget (Health & Community Services 1996d:19). Whilst this target was termed ‘notional’, it did indicate to regional managers, by then responsible for allocating local budgets, that funding the PDRSS sector was serious business.

Conclusion

In summary, this brief historical excursion is intended to reclaim a bit more of the past, reveal its diversity and acknowledge some of its influential figures.

Note: This is a modified version of an article published in the June 2007 edition of Negentropia, the Newsletter of the Association of Mental Health Social Workers.

References


Recovery and Partnership
Putting the Recovery in the Prevention and Recovery Care Model

Joanne Petrenko, Linwood Senior Clinician, Eastern Health and Petrina O’Connor, Program Manager, ARAFEMI

The term ‘recovery’ evokes a variety of responses from various health professionals, and possesses multiple definitions in the literature. Clinical and Psychosocial Disability Rehabilitation Support Services (PDRSS) have traditionally held differing views of this concept, yet within the Prevention and Recovery Care (PARC) model of service delivery, these two services must collaborate to deliver a unified vision of recovery.

The Linwood PARC service located in Melbourne’s Eastern region, was the second PARC program to be established in 2004. This program has been operational for three years and, during this time, the two services have developed a solid, collaborative working relationship that has enabled the delivery of a cohesive recovery-orientated approach in the PARC model. It is important to distinguish the term recovery within the PARC title, as opposed to the recovery-orientated approach, which acts as an overarching philosophical and practical framework.

Prevention and Recovery Care pertains to the treatment and support options available, as possible alternatives to admission and following discharge from inpatient services. In this sense, the term recovery refers to the treatment and support a consumer receives following discharge from a psychiatric inpatient hospital setting. Yet a recovery-orientated approach can be applied to the continuum of treatment options available to consumers who are either:

- displaying early signs of deterioration in mental health
- requiring more intensive support to prevent a relapse and the possibility an inpatient admission occurring, or
- are experiencing significant barriers to their successful return home after admission to an inpatient service.

The recovery-orientated approach at Linwood encapsulates a sense of the uniqueness of each consumer’s recovery experience. The model incorporates a sense of self, empowerment, hope, social connectedness, meaning and involvement in the community (citizenship, work, and social).

Linwood staff value the importance of consumers working on their mental health issues and developing skills to manage their symptoms. O’Regan and Fisher, proponents of person-centred recovery highlight that whilst cessation of all mental health symptoms is not essential for recovery to occur, the management of the symptoms is in some way essential. Through this process, the consumer gains a greater sense of control.2 This is an important connection where the client-rights value system. Although many have written about the controlling and—at times—coercive discourse of mental health, particularly in the acute settings, Linwood suggests that recovery-based practice is not only possible in the acute PARC setting; it’s essential. To fail to do so would be to replicate ‘a ward in the community’. This is exemplified by the fact that consumers attend Linwood on a voluntary basis. They utilise the PARC environment as a support for their transition home, and is considered a therapeutic environment where they can regain a sense of control, reconnect with the community and be supported to manage their mental illness.

Acute settings provide unique challenges to consumers and staff working together; necessitating the preservation of the balance between duty of care, dignity of risk and consumer rights. A recovery-based approach, with values of respect and transparent communication, provides for greater partnerships between the consumers and staff, and increases the probability of greater outcomes for consumers from a bio-psychosocial perspective.

It’s all about partnership…

One of the most critical components to implementing a recovery-orientated approach within the PARC environment is the relationship between clinical and PDRS services. Without a unified vision and a collaborative approach within the partnership, consumers would be left with a fragmented, discordant service. The ingredients for a successful partnership encompass the following qualities required of individual workers, whether they be employed by a clinical service or a PDRS service:

- commitment to a unified vision of service delivery
- shared understanding to the values and philosophy of a recovery orientated approach
- the ability to view the partnership as one team
- an understanding of individual roles and responsibilities, and how both services compliment each other

Acknowledging that the PDRSS and clinical services are the products of different discourses and histories, it is also important to focus on the commonalities so that a shared approach can be developed.
Interview: Lisa Pearson  
Deputy Regional Manager – Hume, Mental Illness Fellowship Victoria

Mental Illness Fellowship Victoria PARC (Prevention and Recovery Care) service in Shepparton, Victoria provides clinical and psychosocial rehabilitation services on the one community-based site. The PARC service is operated by Mental Illness Fellowship and Goulburn Valley Area Mental Health Service (GVAMHS). Mental Illness Fellowship manages the PARC service, providing general supervision and care, psychosocial rehabilitation and therapeutic group activities. GVAMHS provides intensive assessment, treatment planning and specialist mental health care.

The Victorian Minister for Health officially opened the PARC service in March 2004. Lisa Pearson, Deputy Regional Manager – Hume with Mental Illness Fellowship Victoria, talks to us about her experience of the PARC service in Shepparton.

Why are PARC programs an important part of the mix of services? 
PARC services provide a program option between the community and the in-patient unit. They improve the opportunity for hospital diversion through intervention and early assessment and treatment. They also provide for a smooth transition from hospital to returning to live in the community. While a resident is at a PARC assessment, treatment and monitoring of their mental state is managed by the clinical team; the psychosocial rehabilitation team identifies and addresses their areas of need, in order to promote independent living in the community.

What was your experience earlier on in the development of this PARC service? 
The importance of on-going communication between all parties was very important. There was a pre-existing partnership between GVAMHS and Mental Illness Fellowship Victoria, and regular monthly partnership meetings were, and continue to be held. The service context of the PARC program was clearly outlined and represents an innovative model of service delivery being piloted in a rural environment. We knew it increased service options to participants and would alleviate the burden of care upon carers.

Interviewed by newparadigm Editor, Matt Clear
What have been the key learnings over the nearly four years?

- That it is imperative to have formal and informal opportunities for communication, at all levels of the partnership.
- It is important that continuous review of quality of service delivery and identifying areas for improvement takes place.
- Over time there has been an environment of mutual respect that has developed between clinical and PDRS.
- That PDRS staff working in a PARC service are competent in observing and identifying behaviours that indicate wellness and illness.

PARC services bring together the clinical and non-clinical PDRS services and supports.

What are the key challenges with this?

- To clearly identify the role of each team.
- To articulate the specialised experience of each team.
- Adequate psychiatrists available to ensure timely psychiatric review.
- Continuous review and education of staff about the service system with the inclusion of PARC services, i.e. referral pathways, documentation and understanding the role of PARC services within the acute service system.

What’s working?

Past participants of PARC programs reported that they initiated earlier contact with triage and requested access to a PARC service (self initiated early intervention).

Identification of individual needs were able to be addressed at the PARC service. Plans were developed for longer-term needs to be met in the community after the person leaves a PARC service (i.e. connection with Home-Based Outreach, day programs, community houses, education and employment services).

Because PARC services provide individual self-contained units, daily living skills are readily assessed. This provides an opportunity to introduce or reinvigorate someone’s interest in leisure activities such as swimming, art, woodwork and gardening. It’s an opportunity to provide individual and group education in areas such as the mental health system, relaxation, coping skills, community resources etc.

What’s not working?

I would like to hear more about being innovative with the day patient places at PARC services. We have some good examples of it working, but demand is much lower than demand to reside at a PARC service.

What do clients tell you about their experience of PARC services?

- That PARC services provide a safe and friendly environment where people get to meet their goals when they are ready.
- That the staff are friendly.
- That they enjoy their own unit, to be able to cook for themselves and have family visits.
- That they enjoy the activities available to them, whether it’s sport and leisure, art and/or the educational programs.
- That the provision of push bikes assists with independence in regards to transport.
- That access to the day program (M1 Centre) provides alternative programs for them to engage in.

Is this PARC service satisfying the identified need of diverting hospitalisation and promoting recovery following an in-patient admission, or is there work in refinement and/or other services?

From our point of view we have had quite an increase in Step Up participants over time and this aids in early assessment, treatment and intervention. The option of a PARC service reduces the number of days people are hospitalised.

Do you have evidence that supports the implementation of a PARC service?

We collect a range of evidence including qualitative feedback from participants, demographic information, areas of need based on discussion with participants, information from Basis 32 and CAN that assist in the identification of goals the individual sets while at a PARC service. The Individual Program Plan enables staff and participants to track goal attainment.

PARC services are springing up all over the place and appear to be embraced as a model of the future. What advice do you give to organisations forming partnerships?

Communicate, provide role clarity and reinforce that both partners have skills and expertise that they bring to the union and both parties can learn from their partnership.

PARC services provide a program option between the community and the in-patient unit... They also provide for a smooth transition from hospital to returning to live in the community.
Doutta Galla Community Health Service is the leading provider of community health services for the Inner West of metropolitan Melbourne, operating in the municipalities of Melbourne and Moonee Valley. In addition to a comprehensive range of allied health, counselling and dental services, Doutta Galla is the major provider of Psychiatric Disability Rehabilitation and Support Services for the Inner West. This suite of programs, provided to people who have experienced a mental illness, include Outreach, Day Programs and a range of Accommodation service types. These include Janoak (a DHS-funded Supported Residential Service), Chiron (long-term supported group accommodation), Rocket (youth-specific residential psychosocial rehabilitation) and Arion – the subject of this article.

Background
Arion is an eight-bed Step Up/Step Down program located in Flemington, Melbourne that operates as a partnership between DGCHS and the Inner West Area Mental Health Service. The program’s principle aim is to assist with the prevention of, and recovery from, acute relapse. Clients of Arion can currently stay a maximum of six months with the program. The program also aims to assist with relapse prevention through ensuring that appropriate linkages with community services are in place prior to exiting from the program.

Arion and PARC
It is important to state at the outset that the Arion program is not classified as a PARC program. Arion was initially established as a Hospital Admissions Risk Program (HARP), and was, at that time, solely a Step Down unit. The express aims of the program at this time were to assist with the easing of bed pressure at the Royal Melbourne Hospital – both in the Emergency Department and the Acute Ward. Victoria’s first PARC was established in Shepparton some six months prior to Arion’s opening in April 2004; a Step Up component was introduced to Arion in November that year. The reasons for this were to bring the Arion program closer to the PARC model, and to offer broader opportunities for consumer access to the service, thereby improve outcomes for the client group.

The introduction of a Step Up component to the program means that Arion functions in much the same way as the existing PARC units. However, the upcoming evaluation of PARC services will not include the Arion program. This article serves as a partial evaluation of the program, particularly in terms of how the service compares—in a functional sense—to the existing PARC programs.

A comparison between Arion and the DHS PARC guidelines, reveals many commonalities in terms of the program’s current functioning.
These commonalities include:

- Eligibility assessment criteria.
- Involvement of the Area Mental Health Service in identifying and assessing potential clients.
- For consumers: strengthening of gains made during in-patient phase; ensuring provision of appropriate types and levels of clinical treatment and support; providing a range of psychosocial treatments and supports; facilitating a client to their usual environment.
- Governance: The AMHS is the fund-holder and contracts DGCHS (PDRSS) to manage the residential support component.
- The catchment area for Arion is the same as that of the AMHS.
- The site location is easily accessible to all relevant clinical teams and the RMH in-patient unit.
- Whilst at Arion, linkages are established with supports that can be sustained on discharge.
- Key service tasks: Joint processes between the PDRSS and AMHS in terms of entry, management and discharge of consumers; comprehensive assessment processes: developing of individual plans; Liaison with consumers’ ongoing treatment provider(s).
- Staffing: Provision of access to specialist mental health staff 24 hours, seven days a week; Staffing model is a combination of clinical staff and employees of a PDRSS.
- Case managers maintain involvement with consumers for the duration of the PARC stay.
- Information management: Admissions and discharges are recorded on CMI; bed activity is recorded; average length of stay is recorded; occupancy rates are recorded; PDRSS collect and report on QDC data.

Functional differences include:

- Decisions regarding entry to, and exit from, the Arion program are the joint responsibility of the Arion Team Leader and clinician, rather than being the sole responsibility of the AMHS.
- Arion has a maximum length of stay of six months.
- Arion does not provide on-site structured group activities.
- Entry to Arion does not mean that a consumer requires a level of clinical intervention greater than can be provided through CCT, MST, HOPS or CAT. In most instances, this level of clinical care, with the appropriate communication from Arion staff, will suffice for consumer needs.
- Arion does not, at this stage, provide a service to consumers who are not currently residents at the program (this is because the program does not offer day program-like group activities).
- Staffing: In terms of PDRSS staffing, Arion has a Program Coordinator, a Team Leader and two Support Workers. Domestic duties and after hours staffing is provided by Personal Care Workers.

In looking at the functional differences, particular points warrant further context and explanation. There are:

- length of stay, on-site activities, and the staffing model.

Length of Stay

As stated earlier, Arion was established as a HARP program, and purely as a Step Down unit. Overall design of the model was largely the responsibility of key clinicians with the IWAMHS, and took into consideration the varying potential needs of the client group who populate the acute ward of RMH. A core issue was defined as exit points. Consumers exiting the ward would be going to a range of destinations, including the family home, single accommodation, residential psychosocial rehabilitation and emergency accommodation. At this time, consumers awaiting placement in residential rehabilitation services (e.g. PDRSS residential programs; CCU) had limited options in terms of suitable pre-placement accommodation types. If consumers had been identified as being suitable for residential rehabilitation, a return to the family home or single accommodation could, in many instances, result in re-hospitalisation prior to placement. Eviling clients from the ward to emergency accommodation had also proved to be problematic: such environments can often exacerbate symptoms and stresses, resulting in either re-admission to the acute ward, or consumers being lost to mental health services.

In looking at this issue, the experience of the AMHS CCU determined the Arion length of stay. At the time, the waiting period for a bed at the CCU was approximately six months; it was determined that a maximum LOS of six months at Arion would allow clients who no longer needed acute care, to remain in a well-supported environment until such time as a bed became available in the appropriate accommodation service. Being housed at Arion during this time would also provide a useful platform for engagement with appropriate services, and would give staff and consumers an opportunity for early identification of needs relevant to the move into longer-term accommodation.

Another issue that became apparent early in the life of the program, was that the six-month LOS could prove to be useful for the segment of the population that experiences both mental health issues and homelessness. The City of Melbourne, which comprises half of the catchment area, has the highest homeless population in Victoria. In the majority of cases, consumers who entered the ward from a state of homelessness were discharged to inner-city emergency accommodation services. The challenging nature of these environments meant that homeless consumers would often leave these services soon after discharge from the ward, and would often reappear in the RMH Emergency Department when picked up by clinical services within a comparatively short time frame. The use of time at Arion as a platform for engagement with services and the consolidation of clinical treatment regimes, has meant that significant outcomes have been achieved with this population, and many consumers have been able to be placed in long-term accommodation appropriate to their needs.

It is also worth stating that—as with the PARC model—the majority of clients at Arion are with the program for 28 days or less. However, a six-month LOS, whilst falling outside of PARC guidelines, demonstrably contributes to reduced acute admission rates and bed days for the client population of the inner-city catchment area.

On-site Activities

Group activities do occur at Arion, as they would in any shared living arrangement. Meals are generally eaten together, games are played – such as pool and table tennis, DVDs and TV are watched as a group. However, the more formal group activities that are found in Day Program settings, are not a feature of the Arion program. The reasons for this are:

- DGCHS operates over two municipalities: the Cities of Melbourne and Moonee Valley. DGCHS has operated the Common Ground Day Program out of its North Melbourne site for some years, and in January 2007, took over the management of the Boomerang Club in Moonee Ponds – one of the longest-established day programs in the state. Therefore DGCHS has a day program in each of its municipalities. Clients of Arion are, wherever possible, linked into either or both of these programs prior to exiting from Arion. A significant number of Arion clients are already regular attendees of these programs; an admission to Arion may assist with a re-introduction to regular day program attendance.
- One of the primary functions of Arion, as per PARC guidelines, is the establishment of community linkages prior to a client’s exit from the program – linkages that can be sustained when the client has returned to the community. With this in mind, a decision was made early in the life of the program, that group activities would occur in the community, and through resources that can be sustained when the client has moved on from Arion. Having two-day programs within the organisation, and well-established links with community resources such as neighbourhood houses, has meant that clients of the program have been able to either commence or re-commence community group attendance whilst being a resident with the program.

Staffing Model

The staffing model of Arion is unique amongst Step Up/Step Down programs in a number of ways. The most significant of these is the employment of Personal Care Workers as well as Support Workers. The staffing model is as follows:

- Coordinator: Manages both the Arion and Janoak programs. Responsible for administrative processes, networking, program development and supervision of Team Leader and Support Workers.
- Team Leader: Manages the day-to-day running of the program. This includes primary responsibility, along with the Arion clinician, for all intake and exit processes, including managing referrals, assessments and all data associated with admissions and exits. The Team Leader is also responsible for supervision of the Personal Care Workers.
- Support Workers x 2: Working business hours, the SWs have individual case loads, and take responsibility for liaising with all relevant parties e.g. PDRSS providers, case managers and family members. SWs, as well as clients, are responsible for establishing community linkages relevant to client needs, and for practical assistance and support for clients of the program.
- Arion clinician: Is a member of the IWAMHS MST, and is also very much a part of the Arion team. Works with the
Schizophrenia and Schizoaffective Disorder together account for 28 per cent of all primary psychiatric admissions. Most clients were admitted for 28 days or less. As previously stated, this has been almost invariably a result of a longer than 28-day stay to RMH acute admissions, but the clinical service system as a whole reflects the overall success of the assessment process in determining a client’s state of ‘readiness’ for admission to the program.

At the conclusion of the first 12 months of operation, collection and analysis of information on acute admissions and length of stay began at Arion. Acute data was collected for the 12 months prior to Arion admission, and 12 months after Arion discharge. Figures obtained are applicable not only to RMH acute admissions, but the clinical service system as a whole. Figure 4 indicates that, between April 04 and July 07, there has been an overall 54 per cent reduction in acute bed days for clients who have experienced an Arion stay.

If the key aim of the PARC model is to maximise the prevention of and ensure the recovery from acute relapse, then Arion is clearly meeting these challenges. The tailoring of the service to meet the needs of the particular demographic of the Inner West, in terms of length of stay and linkages with appropriate accommodation, clinical and other relevant community services has resulted in significant reductions in acute bed days for most clients who have experienced an Arion stay. Prevention is not only about imminent acute episodes, it is also about the prevention or reduction of future acute bed days and admissions. Arion is clearly succeeding in these areas.

Figure 1: Clinical Teams
Figure 2: Exit Points
Figure 3: Direct RMH Re-admissions
Figure 4: Pre & Post Arion Acute Bed Days

**Conclusion**

Flexibility of program structures is an expectation of services operating within the PDRSS sector. After four years of implementing Step Up/Step Down services in Victoria, it is anticipated that these models will grow and change according to the needs of the clients of these services. Whilst Arion is not a PARC unit, it does operate as something of a hybrid model—particularly in the provision of longer-term beds. If the key aim of the PARC model is to maximise the prevention of—and ensure the recovery from—acute relapse, then Arion is clearly meeting these challenges. The tailoring of the service to meet the needs of the particular demographic of the Inner West, in terms of length of stay and linkages with appropriate accommodation, clinical and other relevant community services has resulted in significant reductions in acute bed days for most clients who have experienced an Arion stay. Prevention is not only about imminent acute episodes, it is also about the prevention or reduction of future acute bed days and admissions. Arion is clearly succeeding in these areas.

**Acknowledgements**

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<th>Acronyms included in this article:</th>
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The Arion Program is an eight-bed Step Up/Step Down facility located in Flemington, Melbourne that began operating in April 2004. The program provides a space for recovery from, and prevention of, major episodes of acute mental illness. Arion has, to November 2007, worked with approximately 190 clients over a three and a half year period. The following case studies represent some of the outcomes achieved with four clients of the program, representing a mix of gender, age group, Step Up/Step Down and length of Arion stay.

01. RW: Male 59 Y.O.
R was admitted to Arion as a Step-Down client from the RMH acute in-patient ward after experiencing a relapse of a long-standing bipolar disorder. He had been living in a rooming house in Carlton, for several years. However, when problematic relationships began to take their toll at this residence due to gradual changes in clientele, R was moved to another boarding house, run by the same support service. R was at his new rooming house for a short time when he became unwell and was hospitalised. This was identified as being mainly due to a lack of opportunities for interaction with fellow residents, resulting in R feeling isolated.

When R came to Arion, he was still ‘in transit’ from his first rooming house, and support was required by Arion staff in order for R to retrieve belongings from both rooming houses. He was able to keep his belongings in his room at Arion—which was a great source of comfort for him—mostly because his interests were around horse and dog racing, and he had many photos, drawings and trophies.

Due to some long-standing health concerns, R was closely monitored whilst at Arion. He had experienced problematic issues in terms of his mental health medications interacting with physical medicines. Close relationships between medical, allied health and mental health services were essential in monitoring and treating R’s physical and mental health during his time with the service. Arion support staff played a key role in establishing contact with, and maintaining communication between, all relevant services involved in the range of R’s care.

R’s exit point was planned to be a low-level aged-care facility. Due to the waiting time for an available bed, R was admitted to the long-stay stream at Arion, i.e., a maximum LOS of six months. R’s case manager organised an ACAS assessment for R, which took place at Arion. During the wait for R’s aged-care accommodation, he participated in a transition program, where he was gradually introduced to his permanent home. R’s stay at Arion lasted 90 days.

Arion was able to provide a supportive environment, along with company for R, who was very sociable. During his time at Arion, R experienced positive social interactions with other residents. This contributed significantly to his recovery from what had been a distressing period in his life. Arion staff were able to assist with R’s transition to more stable accommodation than the rooming house environment; the benefits of a stable environment and the development of a comprehensive shared care plan between clinical, community health, and non-clinical PDRS services resulted in a positive outcome for R, and gave him the assurance of a supported future.
2. VC: Female 46 Y.O.

V was admitted to Arion as a Step-Down client from the RMH acute in-patient unit after experiencing a relapse of schizophrenia. When V came to Arion, her exit point was the family home. V had lived in the family home her whole life, and her parents had primary responsibility for her care during the 27 years she had been living with a mental illness. V’s mother had died the previous year, leaving V’s care in the hands of her ageing father. V arrived at Arion with a plan to stay with the program for up to 28 days. However, the presence of V’s many physical health issues and symptoms of schizophrenia indicated that she could benefit from an extended stay at Arion. The principle aim of an extended stay would be the securing of a placement with a residential psychosocial rehabilitation facility.

Arion staff arranged for an Occupational Therapy assessment of V’s self-care skills and potential for rehabilitation whilst with the program. This assessment was provided through the IWAMHS. The ADL assessment of V revealed that she did have the potential to expand her skills whilst living in a supported setting. With this in mind, V was referred, and eventually moved to, the IWAMHS CCU. V stayed for some months at the CCU before eventually returning to the family home, with increased ADL skills and a subsequent lessening of the burden of care for her father.

Arion’s involvement with V’s comprehensive health concerns included assessment of needs, practical and emotional support, encouragement and the fostering of closer ties with relevant services. This included assessment of needs, practical and emotional support, encouragement and the fostering of closer ties with relevant services. Services were tailored to V’s clinical and practical needs at that time; and V felt safe, and was not confident that she could continue his recovery at home.

Some months later, S was referred to Arion again – this time in a Step-Up capacity. It was clear that S felt he had benefited from his first stay at Arion, despite his issues about exiting the program. He had not self-harmed after his first Arion admission, despite continuing to experience difficulties in his personal life. As the conclusion of S’s second Arion stay approached, it became apparent that S was once again at risk of self-harm should he be discharged to his home. At this point, consultation with relevant services occurred, resulting in S being advised that self-harming after Arion would probably result in an acute admission. This would mean that, as a prevention-focused program, Arion had not worked for S in averting an expulsion decision by those ruling on his suitability to keep him in the future. S expressed his understanding that the Arion program may not be an option for him, should he continue to self-harm. This was a major factor that contributed to his decision to put an end to self-harming.

Conclusion

Arion, like all currently functioning PARC units, has utilised a flexible approach when working with clients of the service. Needs analysis is a major part of the work, and it is in consultation with all key stakeholders, that often determines the length of time a client will stay at Arion. The basic psychosocial rehabilitation goal is flexibility of service, however, that may change during the client’s stay. Outcomes such as those demonstrated in the case studies provided, could not have been foreseen at the time of admission to the program. It was the willingness of staff and clients to work together towards a desirable outcome that resulted in significant achievements for the program and its clients, at both an individual and sector-wide level.
The Springvale PARC service recently celebrated its second birthday after beginning the service in October 2005. The service is located in Royal Ave, a residential area just a short walk from the main shopping strip on Springvale Road, Melbourne. Springvale PARC service is delivered in partnership with Southern Health and Eastern Region Mental Health Association (ERMHA).

The Facility
The initial twelve months of development of the program was largely dedicated to locating a facility in a geographically central location that targeted the large catchment area, which encompassed Mid South, Dandenong, Casey and Cardinia and the Peninsula.

The building for the Springvale PARC service was originally managed by The City of Greater Dandenong as a rooming house for homeless youth who were still attending school. Unfortunately, this project generated a great deal of upset amongst immediate neighbours and as a result, it was closed down. The PARC program, which promised to be staffed 24 hours a day, seven days a week, attracted little objection from the locals who attended an open meeting to hear about what was being proposed for the building. As a result, renovations began.

Originally, the building consisted of five small bed-sit units similar to motel accommodation. Each unit had its own bathroom, a cook top and small fridge. The cook tops and fridges were removed from the existing rooms and another five bed-sitting rooms were added, again each with their own bathroom. The renovation also included adding two staff rooms and a consulting room, and refurbishing the kitchen, main communal area and the laundry.

Having all the rooms under the one roof has given the building a community/homelike feel and provided space conducive to emphasising peer support and interactive group participation approaches.

Developing the Program
ERMHA, Southern Health and Peninsula Health began the collaborative program approach by strengthening their working relationship. Each developed a better understanding of the Clinical and PDRSS roles and responsibilities, and these remain clearly defined. This partnership highlights that different elements of the service system can work together to ensure consumers have access to an integrated rehabilitation and recovery care response.

Southern Health’s Dandenong CAT team provide clinical treatment and care to all residents at the Springvale PARC service. The CAT registrar is based at the facility twice a week, and a further 2.4 CAT positions are designated to the program. Monday to Friday the PARC CAT staff work a day and evening shift, and a day shift, which operates on a weekend. The ERMHA team are at the PARC service 24 hours, seven days a week. This structure bases staff from both PDRS and Clinical services at the PARC facility and has contributed to the development of a positive working alliance.
Key elements of this process involved the following:

1) The building of functional working alliances at the management and staff level to improve the level of integration between the two services. Meetings between ERM-HA and Southern Health managers and team leaders began at regular intervals for nine months leading up to the implementation of the program. A Memorandum of Understanding was developed to formalise the new working relationship.

ERM-HA staff started an orientation and training program six weeks prior to the opening, which included shadow shifts with the CAT team.

2) The implementation of practices to provide sustainable shifts with the CAT team.

ERMHA staff started an orientation and training program six weeks prior to the opening, which included shadow shifts with the CAT team.

The initial PARC program planning meetings occurred at shift changes for hand over appointments and visitors. The meetings also play a part in building a sense of comradeship amongst the residents.

The success of the program very much hinges on the ability of the staff to be able to make a connection with the program participants. This is perhaps the main challenge for staff, as it is within these relationships that progress can be made. From this connection, trust can be developed and this is important for helping people to develop and work on their individual goals. The average stay in a PARC service is about 17 days. However, as the program is an ongoing process. Many of our client group are typically a new client is assessed for their suitability and if accepted, they arrive at a PARC service within 24 hours of their assessment.

Summary

Relationships play a vital role in the recovery process. The relationship between Clinical and PDRSS staff provides an important example and ‘sets the tone’ of the service. An environment built around having a common sense of purpose, where people are treated with respect and dignity and all contributions are acknowledged and valued, provides a setting where rebuilding a life with purpose and direction is a viable possibility.
My name is Daniel and I’m 39. Over the past eight to ten years I have been in hospital about ten times. The most recent time was in April this year. Hospital can be a fairly difficult place to be when you are unwell. At one stage, I was sharing a room with four other blokes, so there wasn’t much personal space. The focus while in hospital was on the illness and medications and most of the time you weren’t seeing people at their best. It was not the most restful of places and you would often hear people screaming in there. You got used to others making decisions for you and there was a routine for everything. Most things were regimented, like what time you got out of bed, when you could watch TV and when it was time to have a meal. In hospital, when it came to meals, the food was just there; you didn’t have to think about it. I couldn’t tell you how many days I actually spent in hospital, as one day just merged into the next. It generally felt like I was going backwards while I was in there, and that I was actually getting worse. The place seemed to be more like a prison than a place of recovery.

While in hospital my doctor talked me into going to a PARC service. Initially I didn’t think that I was ready, but after a while I agreed to try it. When I got to the PARC service it was a bit overwhelming at first, but I soon found it was a good place to be. It was great to be given more freedom. I also really liked the set up there. I got to have my own private bedroom with an en suite. The communal area was a really welcoming and inviting space too. It was a large open room with lots of comfortable seating, complete with a large screen TV. Each day, we would start the day with a meeting in the communal area to discuss what would be happening that day. We would go around the group and see how everyone was feeling, and then have a say in what was going to happen. We were also involved in the day-to-day running of the place like menu planning, shopping for groceries and cooking the meals. This type of approach helped me quite a bit.

Many of the people who went to the PARC service struggled with issues such as self-confidence, making it difficult to feel that you were able to contribute to the decision-making process. I initially found it hard to contribute to the conversations where decisions were being made, but after about a week or so, I became more comfortable with this. The improvement in my frame of mind in this short period of time was significant; my mother noticed a difference in me after my first week at the PARC service.
In hospital, everyone was on their guard; probably a self-defence mechanism. People didn’t generally talk to each other very much. In contrast, the PARC service was like an extended family where the focus was around getting on with living. At the PARC service I felt comfortable talking to the staff and felt that they had a genuine interest in my wellbeing. To be fair, I know that the hospital staff had a very large caseload and finding time to have one-on-one time with the patients would be really difficult. The smaller number of residents at the PARC service allowed the staff more time to give attention to the people in the program. The PARC setting was also a more relaxing and positive environment than hospital.

After I left the PARC service it felt a little strange. I had moved out into a caravan, which was pretty cold and not much fun. I had become used to having people around me: here, I was on my own. However, while I was in the PARC service I had been linked in to ERMHA’s Pathways Program, which helps people find accommodation. This kept me very busy looking for better accommodation and kept my mind focused. At the caravan park there were a few rough characters who were into drugs and all sorts of other questionable activities. So keeping myself busy and spending most of the time out of the caravan park was a good thing for me. I managed to stay focused on having a future.

I managed to develop a few cooking and house-keeping skills, which have been really handy. The PARC program helped me to move out of my depressed state.

In summary, I would say that the PARC program offers people a safe and supportive place from which to move forward. It helped me learn how to shift my focus from dwelling in the past, to looking forward to a life with a future. While in the PARC service, I also learnt a few tricks: I managed to develop a few cooking and house-keeping skills, which have been really handy. The PARC program helped me to move out of my depressed state. If I had walked out of hospital and not gone to a PARC service I think that I would have ended up back in hospital.

Recently, I went through another difficult time. My worker said to me that she would push to help get me into a PARC service before she would try getting me into hospital and this was a really encouraging thought. This prospect wasn’t nearly as scary as the thought of having to go back to hospital.
My name is Julie and I spent some time at the PARC service in Springvale during October this year. Prior to going into the PARC service, I was admitted to hospital for the fifth time this year since March.

I was pretty doubtful that things were going to get any better until somebody suggested that I go to a PARC service before going home, as it might be able to help me along a little bit. I was a bit funny about the idea at first, but I knew of other people who had been there and thought it was great, so I decided to give it a go.

Upon arriving at the PARC service, I was greeted by a staff member who showed me around the house and introduced me to the other residents. I immediately felt welcomed, as everybody was very friendly. It was fantastic! The kitchen was spacious, the lounge room was very inviting and comfortable and the backyard was lovely. Best of all, I had my own room, my own privacy and space.

The PARC program was amazing; it was nothing like hospital. It had a very home-like feeling to it, yet still had support from the staff and the CAT team. I found that I was able to get well. I really benefited from being there, as there was always an outing of some sort, which got me motivated. I enjoyed participating in the group meetings along with being included in meal preparation and with the cleaning up.

I would highly recommend PARC services to anyone. It was the best experience and I have come out of the program feeling 100 per cent better than when I went in. Without it, I wouldn’t be where I am today.
Opinion Piece on PARC Services

Janice Chesters

PARC services are a back to the future program, simultaneously a return to the asylum on the hill and a potential move to a new place that is recovery orientated. The asylums aimed to offer a retreat, a place to recover, where combined clinical and non-clinical treatments and care were implemented. PARC services aim to offer timely access to a place to recover with support from clinical and non-clinical professionals and appropriately planned evidence-based recovery-orientated programs.

However, neither the asylum, nor the PARC service can guarantee good recovery-oriented care. Indeed no place can. A lot of things need to go right before a patient’s recovery can be assisted. Firstly, the place needs to be well designed. Secondly, there needs to be an appropriate evidence-based recovery-focused service model in place. Thirdly, the support staff and the clinical staff need to be trained in the model and committed to the work. In addition, suitable patients or clients need to be admitted at the right time and finally, effective governance needs to be in place to ensure that each PARC service is funded adequately and effectively managed in the interests of patients and staff.

Asylums had significant advantages that helped ensure success: a unified corporate structure, a clear management hierarchy and a monopoly on the mental illness business. What they didn’t have was the ability to choose their patients; an effective recovery-orientated model and sufficient financial support and trained staff to do the job required. PARC services are too new to be able to clearly delineate the positives and negatives that apply in all service settings. However, I want to spend the rest of this opinion piece making some suggestions from my limited experience. I invite all of you to reflect on the accuracy or otherwise of my comments. I have used a series of subheadings to focus the discussion.

Funding

PARC services are defined by DHS as sub-acute services and the funding for them is distributed via the local Area Mental Health Service (AMHS). AMHSs are the children of the asylums. They were created in the mid 1990s as a way of channelling Department of Human Services (DHS) mental illness funding into regions. The AMHS became a preferred funding recipient, an arrangement that reduced competition for funding and promised to integrate service provision in a mainstreamed (physical and mental health service environment) community-orientated service. However, AMHSs are in the main dominated by hospital-based leadership and hospital needs.

As time went by DHS also entered into funding and service agreements with non-clinical PDRSS in most regions. In the case of the PARC services, the PDRSS sector has been asked to deliver the bulk of the PARC residential support and rehabilitation and recovery program. Collaboration between the AMHSs and the PDRSS sector is suggested as the best way to ensure an effective service. However there appears to be significant barriers to open, honest and effective collaboration between AMHSs and PDRSS services. It may well be time to reconsider the monopoly on acute and sub-acute funding that the AMHS have. Financial control
It [the model] must be acceptable to and adhered to by both PDRSS and any clinical partners. If the model isn’t right, if there is not shared commitment to the model and if the model is not evaluated and improved then the PARC service will be challenged.

Governance
It seems to me that one of the key issues in the service tension between AMHSs and their intended PDRSS partners is the very different support for boards of management in the two sectors. Hospitals and community health service board appointments are controlled by ministerial appointment and Australian Electoral Commission elections. PDRSS boards or committees of management control their own appointments. Hospital and community health services have access to free, high-quality board training that is regularly delivered across the state. PDRSS boards have had no access to this training. Recently in some or perhaps all DHS regions, some money has been made available for board training.

Without effective, well-trained governance, there can be no equity between AMHSs and the PDRSS sector. The PDRSS sector will remain poorly understood by the AMHSs’s management and board and therefore seem as, at best, the junior partner in any PARC service agreement. In some cases these perceptions of PDRSS inexperience and amateur status will be correct. Without accreditation and board training, good governance and effective service leadership will be unreliable and the PDRSS sector will be open to claims of unreliability and uneven service delivery. All boards involved in PARC services must be confident of their mental health and recovery knowledge and have a strong commitment to effective clinical governance, risk management and effective financial control over the service.

Having an appropriately trained and appointed PDRSS led by an effective Board running a PARC service may overcome the problems associated with collaboration between two very different types of organisations.

Service model/s
To be effective, PARC services need an excellent evidence-based recovery-focused service model. The model must deal with all aspect of the service environment from entry to exit and beyond. It must be acceptable to and adhered to by both PDRSS and any clinical partners (AMHSs). If the model isn’t right, if there is not shared commitment to the model and if the model is not evaluated and improved then the PARC service will be challenged. The development, review and continued commitment to the model, must be committed to by all parties to the PARC service. Again, with a suitable PDRSS service running the PARC services, the implementation of an appropriate model may be easier to implement.

Recovery options
PARC services offer a possible way forward in recovery-orientated services but no place can guarantee recovery or even an effective service. In order to work, PARC services need sufficient funding, good governance including effective clinical governance and risk minimisation, effective service models that are focused on recovery and the whole program including the hotel factors need to be evaluated. Having one organisation run the PARC services seems to me to be more likely to produce good outcomes. Given the recovery and rehabilitative orientation of the program, it seems to me that PDRSS services should be funded to build, run and evaluate PARC services.

Note: Associate Professor Janice Chesters is an academic with a research interest in mental illness services. She also chairs the Board of a PDRSS service. The opinions expressed above represent only Dr Chesters views and are not intended to represent the opinions of any other person or organisation.
My name is Richard and I am 33 years old. I’ve been diagnosed with chronic anxiety disorder and schizophrenia. I have been on medication for this since I was a teenager.

Back in my early 20s, I was on a whole range of medications and I started hearing echoes in my head. I would be by myself and I would hear conversations in my head about my father and the volume was really amplified. I couldn’t handle the noise; it was just too loud. It was at about this time that I had my first hospitalisation. I ended up in Pine Lodge for a couple of weeks, after a period where I was self-medicated and blacking out as a result. Part of the reason for going into hospital was to detox. Since then I have been to Dandenong Hospital four times. The first time I went to Dandenong Hospital, I stopped taking my medication. I had been living in the garage at my father’s place. I became really aggressive and had a seizure.

Last year I had a stint in hospital for five weeks as an involuntary patient. After I left the hospital, I went back into the garage and this was a difficult period for me. I was living there with my partner; we had no other place to live. Then we broke up and this led to another stay in hospital, followed shortly afterwards by another. It was during this last time in hospital that they asked me if I would like to go into a place called a PARC service. I had heard from some of the other patients that PARC services were nice places that had staff there who helped you. I decided that I should give it a go.

A lady named Merle gave me an assessment. She was very nice and very calm. I remember her being really calm because at the time I was really anxious and she calmed me down just through speaking with her. I remember thanking her for making me feel so good just from talking to her. So after this, I was accepted into the PARC service and arrived there two days later.

I can remember walking in and how calm the atmosphere was. There was no tension, everyone was smiling; everyone there was helpful. I remember the staff asking me if I wanted to talk to them about anything and that if I did, they would be able to give me all the time I needed. I thought that this was just the best! The first day I went for a walk with one of the staff members and we just talked. This helped me with some of the confusion I was having. I felt a bit uncomfortable taking all this time to talk about myself, but he told me this was what he was there for.

I spent a little over two weeks at the PARC service, but I would say that it was the best two weeks I had spent in any institution. It was the most effective and the most helpful. The CAT team was really helpful too. They helped me with some family problems I was having and helped me realise what was happening at home. I had become really isolated there and the only time I would leave the garage was to get my medication. This was the only outing I would have. The CAT team offered to speak to me every few days and this really helped me.
I was a mess to the point where I had nothing to live for. When I went to the PARC service it gave me validation. It made me realise that I can do things. I have a sickness and still get messed up at times, but I can see now that once I participate, I feel much better.

Before I was in the PARC service, I didn’t know how to cook. I had never done any housekeeping before either. In the PARC service, we are encouraged to help out with all the things that needed doing. The staff didn’t force us to help, but we were encouraged to.

The PARC service also had morning meetings. Each day we met to decide what needed to be done. I would often put my hand up to help with the meals and there would be staff who worked with us to show us how to put the menu together. We were also asked to keep our rooms tidy at the PARC service and the staff helped us with cleaning.

I kept a diary while I was in the PARC service. Merle from the CAT team encouraged me to do this. I am not very good with reading or writing but she helped me with this. At the end of each day I would look back on what I had written and think about how I had taken full advantage of what the PARC service had to offer me. It wasn’t so much due to the amount support I got, it was the quality of support. I felt a lot more alive; I felt happy, but I didn’t know why.

Now that I have left the PARC service, I have a new place and will be living by myself soon. As soon as I finish my plate or cup, I wash it and put it away. My bed is always made. Sometimes I am a little untidy but nothing like how I used to be. I am a lot more organised now. I do my housework regularly; yesterday I washed my floors. I now vacuum and clean and do all the things I never used to do. I learnt how to use the washing machine while I was at the PARC service and I even have my own washing machine now. I wash my clothes regularly and hang them out on the line.

All I can say is that initially, I was a mess. I was a mess to the point where I had nothing to live for. When I went to the PARC service, it gave me validation. It made me realise that I can do things. I have a sickness and still get messed up at times, but I can see now that once I participate, I feel much better.

I learnt a lot from the PARC service. Merle from the CAT team encouraged me to do this. I am not very good with reading or writing, but she helped me with this. At the end of each day I would look back on what I had written and think about how I had taken full advantage of what the PARC service had to offer me. It wasn’t so much due to the amount support I got, it was the quality of support. I felt a lot more alive; I felt happy, but I didn’t know why.

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Springvale PARC
Personal Story: Vera

I have been to hospital a few times over the past year and I have been in the Springvale PARC program twice now. The first time I went to the PARC service was after I had been in Casey Hospital for a number of weeks and at the time, I was really quite unwell.

I had been feeling pretty confused and somewhat disorientated and would often get angry about things as I didn’t feel like myself. Then before I was discharged from the hospital, two people from the PARC CAT team came out to assess me for the PARC program. Following the assessment, I was accepted into a PARC service. I then left the hospital and went off to join eight other people who were also in the PARC program.

Upon my arrival at the PARC service, I was shown around the building, introduced to the other residents and was given my own room. The rooms there were quite nice, some of them looked out onto the backyard and each room had its own en suite. Once I got used to the PARC routine, I began to settle in. At the start of each day we would meet together with the staff and other residents to check how everyone was that day and discussed what would be happening in the program. It differed a lot from the hospital routine. In hospital things were decided for you, I felt locked in and there was much less freedom. I often didn’t know what was going on while I was in the hospital and I believe this added to my confusion. At the PARC service, I was able to have a say in what was happening and felt there were a lot more choices in what we were able to do. The PARC service was much more like a home environment than a hospital environment. I enjoyed the daily routines and very much enjoyed the social interactions.

I got very involved in the day-to-day domestic duties while I was at the PARC service. Each day residents had the opportunity to be involved in things like meal planning, meal preparation, shopping and of course, cleaning up. I liked helping out as it made me feel better about myself. I also got involved in helping some of the others. There were some residents who needed help with doing their washing and I showed them how to use the washing machine and dryer. When new people came in, I helped them settle in showed them around. Helping others also helped me feel better about myself.

At the end of my first stay at the PARC service, I left and went to stay with my sister. I was still feeling somewhat isolated and it wasn’t long before I became confused and angry again. However, instead of going back into hospital, I was accepted back into the PARC program. Once again, I found being a part of this little community to be really helpful. I got back into the daily routines again and enjoyed the feeling of being helpful. During my second stay at the PARC service, I was referred to an ERMHA program in Beaconsfield. Upon leaving the PARC service the second time, I started participating in the ERMHA program and found that the social contact and support had made a real difference in my life. I no longer felt isolated and I now have things I am involved in during the week. So far, I have managed to stay out of the hospital.

I would recommend PARC services as a really good place to go, where a person’s mental health needs and social/support needs can be met in a very comfortable and positive environment.
What Do We Have and Where Do We Go?

Matt Clear, Communications and Membership Manager and Ben Bailey, Policy and Research Officer, Psychiatric Disability Services of Victoria (VICSERV)

The focus on Prevention and Recovery Care (PARC) services in this issue of new paradigm follows the principle that this journal is a tool to share and explore models of care that directly affect people interested in the psychosocial rehabilitation field.

The Department of Human Services (DHS) describe PARC services as part of a ‘commitment to expanding services for people with a mental illness, and developing innovative models of care.’

The PARC model has certainly created some new and exciting challenges for everyone involved, including those in the PDRS sector. Janice Chester’s article (featured earlier in this issue) highlights some of those challenges and asks some pertinent and legitimate questions. Early on she questions if this is an innovative model of care or a replication of an asylum which had, at its core, a desire to bring together clinical and non-clinical approaches in a system that attempted to encourage recovery.

So, are we merely replicating the past, or are we creating a unique model that provides an important new way of supporting people with mental illness and their recovery journey?

As Joanne Petrenko and Petrina O’Connor discuss, their experience is one where PARC services provide an environment in which consumers are supported to manage their symptoms, and receive treatment and support through daily access and support with both PDRSS and clinical staff within a holistic and client-rights value system. They go on to discuss the importance of receiving support from both clinical and non-clinical partners, and how this partnership is central to the success of the service. The importance of the partnership is also highlighted and reflected on by Lisa Pearson in an interview (in this issue), which discusses the first PARC service and also by Alys Boase, Kim Kerr and Debbie Hooley in their piece about their Springvale PARC service. So, working together, having respect and open communication and being willing to build on the partnership is exceptionally important.

As the Dougs Galla Community Health Service piece articulates ‘between April 04 and July 07, there has been an overall 54 per cent reduction in acute bed days for clients who have experienced an Arion stay’. As the case studies highlight, this emerging and developing form of care is having a real and significant impact.

As part of Psychiatric Disability Services of Victoria (VICSERV’s) commitment to support and develop key aspects affecting PDRSS, the newly established PARC network is indeed working through some of the big questions and challenges faced by the sector on this issue. Some of these challenges are about the mechanics of setting up and developing a new service type. Others are about sharing the best ways to continue to improve partnerships with clinical agencies and how to work within a recovery-orientated framework with a limited timeframe.

Looking fractionally broader, as a sector it is possible to view the PARC model as the apex of the interface between community and clinical support services. It’s this coming together that is of considerable interest as we learn more about the best way to support people with mental illness. It’s interesting to note that in a soon-to-be published VICSERV sector survey analysis between 2000 and 2006 maps that interface.

There were strong links between the PDRS sector and clinical mental health services developed as part of the Cornerstone Project that was launched in 1997. This project aimed to identify ‘good practice’ models of support and care and encourage links between a variety of agencies. In the VICSERV sector survey, 75 per cent of VICSERV members reported in 2000 that they had active, working linkage agreements with clinical mental health services and 73 per cent reported that they had regular, formal meetings with clinical mental health services. This rose in 2006 to over 82 per cent of organisations having links.

Interestingly, relationships between PDRSS organisations and clinical mental health services have continued to improve with a six per cent improvement in the proportion of organisations who rate their relationship as ‘very effective’ or ‘effective’. One further theme, as a sector we need to consider the evaluation of the PARC model. It is developing further and we need to ensure that we keep up to speed with the outcomes that are being delivered within this model of care. We understand that DHS are commissioning an evaluation of the PARC model, but should the PDRSS independently evaluate PARC services from a PDRSS perspective? Of course, if there is agreement that this is important, it is anticipated that many questions follow: What is it that we want to measure? How do we define success of this service type? Are there differences between metropolitan and rural areas? What impact is the relationship between PDRSS and clinical services having upon the respective partners?

To conclude, the conception of the PARC service type is a highly significant one for consumers, their families and the mental health service system as a whole. Implementation is still in its early days and has the potential to highlight and replicate some of the system’s deepest flaws and problems. It also provides a great opportunity to learn from the past and create change for the better. Everyone involved has a responsibility to ensure that we take the latter.

References
Interview: Carol and the CRM
Interviewed by
new paradigm Editor, Matt Clear
The Stables Art Studio

Amanda Laming, Coordinator Stables Art Studio

Prahran Mission has historically been renowned for its use of art as an outlet and a tool to assist people in their rehabilitation process. Participants’ abilities to access art programs within the Mission was dependent on their involvement in the rehabilitation process within the Second Story program, which meant setting goals and working closely with a key worker.

Some artists identified that they had either moved through this process or did not wish to engage with the Mission in this way, but wished to continue to utilize the space and materials so as they could continue to create. The Mission identified that this was an important aspect of artists’ abilities to maintain their wellbeing. In response to this need, The Stables Art Studio was born in 2001.

Recently, The Stables Art Studio relocated to Malvern East and we celebrated the move with an official launch in August this year. Our fantastic new venue offers a larger and more productive space for the artists to work in. The Studio offers artists—living with a diagnosis of mental illness—individual and shared studios in a supportive environment at a low cost. On becoming a member of the Studio, artists have the opportunity to exhibit in The Stables Gallery, access the ceramics studio and kiln and use the Studio library and gardens. There are 17 lockable studios and space for five artists in the shared studio areas with a maximum of 25 members. The artists have access to their studios Monday – Friday, from 9:00am – 5:00pm but we are hoping to extend this in the near future.

The Stables Art Studio compliments a range of other programs at Prahran Mission, which have a strong emphasis on rehabilitation and the recovery process, essentially assisting people to rediscover or renew their identity and sense of role.

For the artists at The Stables, this identity is that of being an artist. The Studio provides a supportive environment where this role and identity can be developed and realised. Although engaging in the creative process has therapeutic benefit, the focus of the Studio is not art therapy. The Studio acts as an anchor where artists can feel contained, with a strong focus on all that is involved in practising art.

As the coordinator, I am responsible for running the Studio. I am an artist and art therapist and find I draw on these qualities as an adjunct to my role here; one that I perceive to be quite complex and multi layered. During the day my focus can shift constantly as I work in response to the needs of the artists as they arise. In a sense I travel with each artist on her/his journey of creative expression. I also support them in their quest to make sense and meaning out of life.

The Studio continues to develop in ways which are primarily in response to the requirements of the artists. As new artists join the Stables, they bring with them their unique qualities and in response to this, the Studio environment continues to evolve.
Interview:
Alan Cotton

Interviewed by newparadigm Editorial Assistant, Kristie Lennon

It was pretty difficult for me as a kid because I was particularly sensitive and I never really had much self-esteem; nothing was ever good enough for my father. I’m one of seven kids. I was brought up in a very rough area of Port Melbourne; at the time it was called the ‘City of Thieves’. My mum was a tea lady. My father was a bricklayer and was pretty violent towards all of us. Mum eventually got away from him and remarried and I ended up being really close to my stepfather.

We travelled around a lot when I was a kid; I think I went to eight different primary schools and three different high schools. I was about 14 when I was in a car accident where my pelvis was broken in four places and I had burns all over my body. Depression started setting in then and I got into a pattern of taking sleeping tablets that wiped my memory completely.

From this, I got really involved in the drug culture, and yet at school I was doing really well; I got two scholarships! I learned to basically cover up emotional pain and sensitivity with drugs. They helped cover up all the pain of childhood. When I was about 15 or 16 I was introduced to the gay scene. I was pretty cute back then so it gave me the confidence to get out there and be whatever I wanted to be.

By the time I was eighteen, I went as far away from my family as I possibly could. I went to live in London for seven years where I worked for a film production company and I also did fashion and made gowns for Princess Diana.

It wasn’t until afterwards that I started to think about it and subconsciously, I knew I was running away as far as I possibly could. I was always searching for some form of security by getting involved with older men. It was almost like I was looking for a father figure. I was using cocaine and smack; everything I was a mess, but at the time I had no idea that there was an undercurrent to what was driving me to be like that.

I was completely raw at detox, that’s where I had to face up to lots of stuff because I had just numbed it out. I learnt awareness skills, how to reach out and how to ask for help. It was such a hard thing to do because I was too embarrassed to ask for help. I thought I was in control but I actually was way out of control. I’m totally drug free now and have been for five years.

I think the crunch really came though, when my sister died 15 years ago. I’m the youngest; she was the second youngest. She died from a heroin overdose when I was 30. We were really close. We were the two black sheep of the family. We always thought we would be there for each other as we got older. She was found in a public toilet at a train station. That just shattered me completely. That’s when I really fell apart and I just used anything I could get my hands on. My mum was sick for a long time. I had to watch her deteriorate away; she had dementure and Alzheimer’s and in the end she didn’t know who we were. That was quite painful. The depression got pretty bad then. I went on medication for it and if anything, it made me worse. Coming off them was one of the most horrific things I’ve been through. That sucked with my head even more than smack or anything else I’d had. So detox was pretty hard.
I moved to Queensland for five years and resurrected my career I started in London. I got into a Queensland theatre company and was clean for six years. I'd lost my creative career with the production companies overseas. Although they loved my work, I was totally ashamed because I was off my face the whole time. When I moved from Queensland back to Melbourne, that's when the shit hit the fan again. I relapsed and then everything went downhill. I lost everything and I ended up living in a Hotel.

On the positive side, I look at my background and what I've been through and I feel it's reflected in my work that I do with kids. I've been able to use my experiences to help encourage kids who are in child protection. That's really rewarding. One client got a mid-year report and it was just outstanding. He's just kicking goals at the moment and I'm his mentor. It's really amazing. I know it sounds really clichéd to say this but if I can use my honesty and insight about my journey to help others… why not?

I remember when found the leaflet for the Stables. I was sitting in Argyle Street Housing because I was about to lose the place I was living in. The leaflet inspired me to get back into doing something creative. Since coming to the Stables, everything's changed. I have an outlet. I'm also able to deal with my depression and talk about it and not feel ashamed because I'm around people who are likeminded. Art has been a way for me to express what I'm actually going through.

I've been coming to the Stables for about three years. Mandy just has this amazing energy where she's there for everybody and she knows us all on an individual basis. She just understands where you're coming from. She's good at dealing with conflict and people's interests. Sometimes people might be arguing about wanting a particular thing, but Mandy keeps sight of what the Stables is initially about: the therapeutic side of using art. It's about the illness; it's not a money-making exercise.

Being creative has always been a big part of my life. It's who I am. It's just a natural progression. To be honest, it's what I've always wanted to do, even though as a child I wasn't encouraged to be creative. I was supposed to be a carpenter or an architect through my father's eyes. He used to say 'You can't make a living out of being creative.'

Creating art is very therapeutic for me. I get to deal with emotional issues and also create something that's really beautiful to look at that people enjoy. A good thing about art is when you're angry, sometimes some really good stuff comes out. There can be lots of movement. That one there [Alan points to one of his paintings], I did that in about ten minutes. To make a living out of it would be just fantastic.

I do yoga and meditation and stretches that make me feel grounded and connected to the universe; these diminish that sense of being alone. Knowing my true self and knowing what the world is about, what life is about helps clarify that great question: What's it all about? I've found that through painting, meditation, yoga, natural therapies and being drug free, I'm the happiest I have ever been in my whole life. I'm no longer scared, I no longer live in fear that people are going to find out what's going on on the inside.

These days I'm a lot more comfortable with who I am. I refuse to live in shame because of my mental illness. I haven't been in a relationship for about ten years, although I recently met somebody who was really interested in me at first. As soon as I mentioned the philosophy behind the Stables and that it's for people with a mental illness, the phone calls stopped. He was just so ignorant. I'm sort of getting over the stigma that's still attached to mental illness. Sometimes I think Fuck, I'm the one with the mental illness, yet at times, I think I have more insight and I'm more together than most people.
Interview: Dianna Huggins

Hello my name is Dianna. I am 28, I am an artist and I have depression. I have been coming to The Stables Art Studio for about a year to practise my art. I have friends at The Stables, whom I refer to as colleagues, and I love talking to other artists. I feel very privileged to be here and a part of The Stables. I’ve learnt how to live with other artists, particularly in regards to my relationship with Mandy. I’ve learnt to accept myself and be comfortable with who I am.

I was 15 when I had my first episode with a mental illness. I did not have much time to think about the illness at all until recently. I feel my illness has taught me a lot and I think I am a more humble person now, even though I am still in the recovery stage. I am searching for direction and consider art as not just a job, but a calling.

I paint from the emotion of a beautiful world in which there are goddesses, angels and knights in shining armour, flowers and fruit. My belief is that having a mental illness has a contributing factor to my art. However I believe that I would still be making art even if I did not have a mental illness. I think the struggle in life brings out the creativity in me. If I had not experienced struggles in life, I don’t think I would desperately need an outlet for creativity to create a magical world in art. I don’t really have a favorite. I’ve got hundreds. I love all my children in some form or another.
Dear Editor,

I write to express my congratulations for the September 07 edition of newparadigm and Parity. I also wish to promote work by HomeGround to bring a new model of housing to Melbourne and to encourage collaborative action to get housing as a central plank of federal and state mental health strategies.

I was particularly encouraged by the article The importance of housing for people with serious mental illness. For me it offered new hope that deliberate planning for the provision of housing and support is not only possible and effective – it is fundamentally important. It also highlighted the critical role that housing plays as a determinant of mental health and pointed out that “when housing and psychiatric care are considered, housing appears to be a better predictor of success than existence of mental health services” (Rosenfield 1990).

I am still amazed at the lack of recognition of the importance of housing on ending the homelessness of individuals, especially those with serious mental illness. This is apparent within government policy, mental health policy and in large parts of the homeless sector.

HomeGround has always operated on the basis that decent housing is fundamental to the wellbeing of all of us. Our experience is that most people who have experienced homelessness are able to successfully maintain public and community housing with adequate outreach support. Our work shows that it is almost futile to try and address mental health or substance use problems while a person is homeless or living in unsafe housing. When we facilitate access to scarce affordable housing, we find that support needs dramatically diminish. Support needs do not necessarily disappear completely and they change over time as people who have finally found a home are able to begin to tackle the many mental health, health, social and legal problems they have accumulated whilst homeless.

In the United States this approach is widespread and known as Housing First. The idea is to assist people experiencing homelessness into decent, affordable, permanent housing as quickly as possible. This happens mostly within the private rental market with the assistance of rental subsidies to ensure they are affordable to the resident. This approach does not present access barriers (such as extensive or intrusive assessments) or require people to comply with mental health or drug treatment in order to get housing. People targeted have often lost hope of getting housing and given up on the system of graduating through crisis, temporary and transitional models that have failed to deliver sustainable exits from homelessness in the past. People targeted are chronically homeless and appear to have serious mental illness. Workers proactively engage with them and offer them permanent housing. Services operating these models find that people are so keen to maintain their housing that they will over time seek help to address things that may put their housing at risk, such as mental health or substance use problems.

See http://www.pathwaysinhousing.org/

While this approach is effective for most people, it is not for everyone and there is a current significant gap in housing models. There is a small group of highly vulnerable people who are unable to successfully create a home in typical housing in the broader community. They are vulnerable to standover and intimidation and unable to refuse access to their housing by people who move in and will ultimately undermine their tenancy. A great deal of work then goes into assisting the person to move
out or into moving out those who aren’t tenants. HomeGround has been working to research models that successfully house this group of people who tend to get entrenched in homelessness, become isolated and suffer significant damage along the way. The typical boarding houses that offer shelter for people are full of violence and intimidation and are absolute hell for people with mental health problems. Supportive Housing is a sector that has operated and improved for over 20 years across the United States. It essentially co-ordinates the provision of housing and support and has a wide range of models within it, from housing and support to people in a specific group of dispersed houses to housing and support to people in specific higher density buildings of between 60 and over 600 self-contained units.

HomeGround has developed a model of Supportive Housing for Melbourne based on Melbourne housing built form and builds on various housing and support components that currently exist within our sector. The model we are proposing as a demonstration project has a combination of features that don’t currently exist in Melbourne and is aimed at providing a home for the most vulnerable people experiencing homelessness, including a large proportion of people with serious mental illness. We are proposing a model with the following features:

- **Permanent housing** – people can choose to stay as long as they want.
- **Affordability** – maximum 30 per cent of income.
- **Self-contained** – each unit has its own kitchen and bathroom facilities.

**Social mix** – of previously homeless and low income earners (approx 50:50).

**Onsite support** – on site case workers, community integration/development, other services outposted onsite as necessary including clinical mental health, health, employment, recreation.

**Controlled access** – concierge model to restrict entry to the building to residents and visitors that residents choose to Onsite and proactive management.

We are proposing the creation of a single building of 100 to 150 units, in the Inner City with high quality amenity and common areas. The building costs will mostly be met with funding made available to Housing Associations with onsite support services operating similar to a combination of existing good case management and psychosocial rehabilitation services. Importantly, the building will offer a secure entrance and, combined with proactive onsite management and support, will ensure people feel safe and can choose the level of interaction they have.

We are very mindful of needing to ensure a high quality, safe, conducive and non-institutional feeling environment and social mix. There are many lessons to be learned from models such as Gordon House (which housed a high scale of people with very high needs in an unattractive and often dangerous environment) and some problematic public housing high rises. The model we propose has many distinct features as described above and seeks to create a safe, attractive, comfortable home for people.

Supportive Housing has operated for two decades in the US and people with serious mental illness are a major client group. There are support-funding streams, which provide per capita mental health support funding which also covers the operating costs including concierge component. Through a demonstration project we will seek to research and articulate the effectiveness and cost reductions associated with people being housed in Supportive Housing.

HomeGround believes there needs to be an increase in the availability of decent, permanent housing and support for people with serious mental illness who are entrenched in homelessness. We also believe in the value of a diversity of housing and support models and providers.

The Rudd Government interest in homelessness is a most welcome change. Their current focus is concerned with shelters and reducing turn-away rates from shelters. Even though most homeless people are found elsewhere and have given up trying to access shelters, this interest is a great start. I congratulate VICSERV for recently convening a meeting of CEOs from mental health agencies to look at tackling the lack of access to decent housing and look forward to working with a broad coalition to achieve social policy change for those most disadvantaged.

**Stephen Nash**
Chief Executive Officer, HomeGround

**Dear Editor,**

I was pleased to support the VICSERV employment campaign, and in particular the need for a national mental health employment strategy.

In my understanding, many, if not most of the issues raised in Chapter 12 of the benchmark report of the National Inquiry into the Human Rights of People with Mental Illness (HREOC 1993)—for which I was a Commissioner—remain to be addressed in strategic ways.

Indeed, since that time, it appears that additional barriers to employment opportunities have been erected through the Job Capacity Assessment process, and the inflexibilities of many current employment practices.

At the time of writing, it is not possible to know whether a new Federal Government, of whatever complexion, will seek to create a new climate for employment and other forms of community participation for people with psychiatric disabilities.

Neglecting the chance to radically reform the entire framework within which mental health and psychiatric services are delivered, would be inexcusable at a time of unprecedented national prosperity.

Yours Sincerely,

**David Hall**
Sometimes when service providers and services users try to communicate, it’s not only like we are speaking another Earth language, it’s like we are from totally alien planets.

Who are the authors? Julian Leff and Richard Warner are psychiatrists trained in the strong British tradition of social psychiatry. Leff is based in England, Warner in the United States. Leff’s work has largely focused on how to improve life in the community for former long-term patients of British psychiatric institutions. In the US, Warner has been active in developing progressive mental health services, such as Cedar House in Boulder, Colorado, a non-hospital alternative providing intensive acute psychiatric care.

What does the book cover? Leff and Warner start by summarising the barriers to social and occupational integration for people with serious mental illnesses, such as disabilities associated with the illness, and discrimination in housing and employment. They go on to examine these barriers in depth, drawing on accounts from twenty consumers interviewed especially for the book, then explore ways to overcome the obstacles. An example is stigma, whether reflected in negative community stereotypes or self-stigmatisation by the person with a mental illness. The authors demonstrate how stereotypes can be changed and stigma lessened, for instance, by targeting education programs at particular groups such as high school students. They also discuss how to reduce self-stigmatisation such as using cognitive therapy to improve self-esteem, undertaking creative activity for self-expression, and joining consumer advocacy groups to gain a sense of solidarity.

The second part of the book focuses on overcoming obstacles to employment. Warner and Leff argue that engaging in work, especially paid work, is pivotal for improving social inclusion. They give lots of examples of successful programs, such as individual placement and support, and social firms, stressing the importance of consumer choice in the process of job-finding. This emphasis on the importance of work is particularly timely in Australia given the November release by the Mental Health Council of Australia of Let’s get to work - A National Mental Health Employment Strategy for Australia (downloadable at www.mhca.org.au).

Why should you read this book? It’s not one for the casual reader. On the other hand, it is a treasure trove for those keen to find out more about why people with a mental illness face social exclusion and how this can be turned around. Leff and Warner pull together both past and current research, and present the findings in digestible form. What gives the book extra clout are the direct accounts by consumers of their experience of discrimination, and also of how they have overcome obstacles. Overall I recommend it highly.

Reviewed by Valerie Gerrand
Independent Consultant

This book tackles a pressing contemporary issue: how to promote the social inclusion of people with serious mental illnesses, particularly the psychotic disorders. The issue is a tough one but the authors are not daunted. Their overall message is optimistic: there are many ways to maximise the social inclusion of people with a mental illness.

Book Review:
Social Inclusion of People with Mental Illness

Julian Leff & Richard Warner
Cambridge, Cambridge University Press, 2006

Pictures by Sue Armstrong
If you’d like to get in touch with Sue about purchasing her art, you can send her an email – sarmstro@bigpond.net.au

Sometimes when service providers and services users try to communicate, it’s not only like we are speaking another Earth language, it’s like we are from totally alien planets.

Sometimes when we are trying to juggle all the things in our lives we enjoy the activity.
New to the Resource Centre

Expanding Support and Treatment Options within Mental Health Services: Service Guidelines on Prevention and Recovery Care Services
This is a Department of Human Services publication and the guidelines in this document have been produced to assist services implementing a PARC program in their area. The guidelines outline the key principles and specify the minimum requirements for PARC services.

Project Report on: An Analysis of the Victorian Rehabilitation and Recovery Care Service System for People with Mental Illness and Associated Disability
This project report by the Department of Human Services highlights examples of good practice relating to the collaboration between clinical services, PDRS services and consumers’ needs.

Contact VICSERV’s Resources Coordinator for information on borrowing procedures and to find out what else is new to the Resource Centre, or visit our website. VICSERV is looking to build on our resources on PARC services for our Resource Centre. If readers know of any further publications on this issue i.e. reports or papers, we would love to hear from you.

New DVDs for Sale
Recovery is Best Practice disc 1 – Ron Coleman
Recovery is Best Practice disc 2 – Dorothy Rowe
An Hour of Power – Ron Coleman and Dorothy Rowe

$22 each or $55 for the set

Two of the most popular speakers on mental health were brought to Perth in 2007 by Richmond Fellowship WA, where they presented on Recovery. The DVDs of these presentations are now available and will be beneficial to trainers, clinicians and managers in the sector.

Ron Coleman is an international speaker, author, mental health trainer and consultant. He is recognised worldwide for his innovative recovery-based practice, training and service designs in psychosis and prevention.

Dorothy Rowe is a world-renowned psychologist and writer and has changed how we understand depression, happiness and creating meaningful lives. Dorothy’s work resonates with both mental health professionals and those who experience or have experienced mental illness.

Contact Psychiatric Disability Services of Victoria (VICSERV) to order your copies and to find out what else is new to the bookshop.
About us

Psychiatric Disability Services of Victoria (VICSERV) is the peak body for Psychiatric Disability Rehabilitation and Support Services in Victoria. These services include housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self help, respite care and advocacy.

Our Vision
A world of opportunity for people with a psychiatric disability.

Our Mission
VICSERV is dedicated to the achievement of the best outcomes for people with a psychiatric disability, their families and their communities.

We do this through:
• promoting the principles and practices of psychosocial rehabilitation
• building and disseminating knowledge
• providing leadership
• building partnerships
• undertaking workforce training and development
• promoting quality in service delivery
• undertaking advocacy and community education.

The mission statement is underpinned by the following values:
• respect, dignity and responsibility
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• interdependence / inter-connectedness
• flexibility and responsiveness
• honesty and integrity
• participation and consultation, and
• camaraderie.

We are committed to honoring consumer and carer experience, embracing diversity, promoting a sense of belonging and inclusiveness, and encouraging innovation.
Membership Application Form

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Street Address

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Type of Membership applied for

○ Ordinary (full)
○ Associate
○ Individual

Is your organisation psychiatric specific support

○ Yes
○ No

If yes, what type(s)?

○ Day Program
○ Home-based Outreach
○ Respite Care
○ Mutual Support and/or Self help
○ Residential Rehabilitation
○ Statewide (describe)

Please describe any other services your organisation provides

The funding level of your organisation (for billing and statistical purposes)

The above named organisation (or individual) hereby applies for membership of Psychiatric Disability Services of Victoria (VICSERV) Inc. and nominates the above-named person as the contact person for all correspondence.

Upon acceptance of this application, Psychiatric Disability Services of Victoria (VICSERV) Inc. is authorised to insert the name of this organisation (or individual) in the register of members of the incorporated association.

We hereby agree to abide by the Rules of Psychiatric Disability Services of Victoria (VICSERV) Inc.

Signed Official Representative

Name

Position

Upon approval of the application by the VICSERV Committee of Management, you will be invoiced for the membership fees due.

If an organisation, please supply a copy of your last Annual Report, and a Statement of Purposes, or other information about your service.

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