## CONTENTS

**EDITORIAL**

Wendy Smith

---

**MENTAL HEALTH AND THE JUSTICE SYSTEM**

Policing for positive mental health outcomes
Elizabeth Crowther

---

Peace of mind: implementing the Victoria Police Mental Health Strategy
Eva Perez

---

Mental health and transition from prison to the community
Paul Atkinson

---

Lighting the match: consumer participation at Forensicare
Julie Dempsey

---

Bundji Bundji – supporting Indigenous young people in the justice system
Freda Haylett

---

Prisons and the perpetuation of disadvantage
Sam Biondo and David Taylor

---

The ARC List
Carrie O’Shea

---

Penal solutions to social problems
Indiana Bridges

---

Neighbourhood justice
Caroline Ottinger

---

Smart Justice: responding to mental illness the smart way
Michelle McDonnell

---

Inter-Church Criminal Justice Taskforce
Antony McMullen

---

Mental health law reform - the Mental Health Bill Exposure Draft and beyond...
Catherine Leslie

---

---

new*paradigm*

is published by

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

**Editorial Team**

Wendy Smith, Editor
Kristie Pate, Editorial Assistant
Anthea Tsismetsi, Content Advisor

**newparadigm Editorial Advisory Group**

Joan Clarke, Allan Pinches, Chris McNamara, Ellie Fossey.

ISSN: 1328-9195

---

**Copyright**

All material published in *newparadigm* is copyright. Organisations wishing to reproduce any material contained in *newparadigm* may only do so with the permission of the editor and the author of the article.

**Disclaimers**

The views expressed by the contributors to *newparadigm* do not necessarily reflect the views of Psychiatric Disability Services of Victoria (VICSERV).

Psychiatric Disability Services of Victoria (VICSERV) has an editorial policy to publicise research and information on projects relevant to psychiatric disability support, psychosocial rehabilitation and mental health issues. We do not either formally approve or disapprove of the content, conduct or methodology of the projects published in *newparadigm*.

**Contributors**

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

RESEARCH
I’ve done my time, now what? The case for living skills interventions for people with mental health issues at risk of, and beyond, custodial sentences
Muriel Cummins and Louise Farnworth

Violence against people with cognitive impairments: a study by the Office of the Public Advocate
Magdalena McGuire

Co-designing mental health services – providers, consumers and carers working together
Karen Fairhurst and Wayne Weavell

YOUR SAY…
Opinion piece
Strengths… time for a rethink?
Maggie Maguire

Member profile
Australian Community Support Organisation (ACSO)
Robb Ritchens

Expression session

Book review

New to the Resource Centre

Coming up in newparadigm

ABOUT US…

Guide on Contributions
• We encourage articles that are approx 1500 words
• Major articles should not exceed 4000 words
• Brief articles should be approximately 500 words
• Letters to the editor should be under 300 words
• All articles should state:
  » a short name of the article
  » the author(s) name
  » the author(s) position or preferred title
  » an email address for correspondence
• Articles should be emailed in a Word file to newparadigm@vicserv.org.au

Guide on Images
• We welcome and encourage accompanying images with any submission
• All images should be emailed as a jpg file to newparadigm@vicserv.org.au
• Please note any acknowledgements/photo credits necessary for the image.

Advertising
We welcome advertising related to psychosocial rehabilitation and mental health.
We have half page, full page and insert options. Please send a message of enquiry to newparadigm@vicserv.org.au to advertise in newparadigm.

Subscriptions
Cost (4 issues): $80 per year. Consumers, Students: $40
Publication schedule: Summer, Autumn, Winter, Spring
Online subscription enquiries: www.vicserv.org.au or please see the form at the end of newparadigm.

Designed by Studio Binocular
Printed by Blueprint

greenprint®
Welcome to the Autumn edition of *new paradigm*. The theme is mental health and the justice system. This was also the theme at VICSERV’s most recent members’ forum. At that event, VICSERV President and Mental Illness Fellowship Victoria CEO, Liz Crowther, spoke about how critical an understanding of mental illness is at every point where an individual might come into contact with the justice system. Liz has worked with the government and Victoria Police over a number of years to ensure that better understandings are in place throughout the system. We are very proud, therefore, to have her write the lead article.

The articles that were commissioned for this edition range in topic from keeping young Koori males out of prison, through to the work two VICSERV members are doing with people who have a mental illness post-release from prison. An overview of the *Victoria Police Mental Health Strategy* is prefaced with some stark statistics showing the amount of day-to-day contact the police have with people who are mentally ill. Several articles describe services that are provided to people who are incarcerated. VICSERV’s colleagues at the Mental Health Legal Centre Inc. have provided another example of their innovative work with prisoners. Julie Dempsey is a Consumer Consultant at Forensicare and offers what might be regarded as a surprising insight into the opportunities for client participation in secure facilities. This edition is rounded out by a topical article on the *Mental Health Bill Exposure Draft* and an article on a wonderful peer-run mental health program in the Victorian Public Service.

The newly introduced research section has been popular amongst readers. It is great to have an article about some sector research with a justice system focus. The Victorian Mental Health Carers Network (VMHCN) and the Victorian Mental Illness Awareness Council (VMIAC) have written an article on working together with staff in a PDRS service to improve quality in service delivery. The model they use is the latest in a long tradition in Victoria of participatory and collaborative consumer research in mental health. It is great to capture this current example to add to the record.

The author of our Opinion Piece states that her attitude to one of the dominant approaches used in community managed mental health services is ‘different’. We think it will promote some interesting discussion amongst our readers. We welcome all sorts of perspectives and are happy to publish replies.

VICSERV has recently signed an MOU with the Dax Centre to reproduce artwork from their collection by people with a mental illness. The Expression Session features the first of these works and it is stunning. Special thanks are due to Charlotte Christie from the Dax Centre for her assistance with this edition.
MENTAL HEALTH AND THE JUSTICE SYSTEM
Policing for positive mental health outcomes

Elizabeth Crowther, CEO, Mental Illness Fellowship Victoria

Mental Illness Fellowship Victoria has recently ratified a policy that sets the framework for our advocacy to improve the experience of people with a mental illness coming into contact with the justice system in Victoria. Improving the capacity of police to understand and manage the challenging needs of a person with a mental illness in appropriate ways, without the use of lethal force, is one of our key advocacy priorities.

Police training and partnerships with mental health services are needed to reduce the risk of harm during police interactions with people with mental illness, and to contribute to more positive outcomes for people with mental illness, police, and the wider community.

For almost a decade now, Mental Illness Fellowship Victoria has campaigned for more and better police training, not only to protect the health, safety and human rights of people with mental illness, but also to better protect the safety of police officers, and, just as importantly, to reduce the criminalisation of mental illness, which feeds community fears and prejudices. These fears and prejudices run in two directions: from uninformed members of the public towards people with mental illness, and from families and friends of people with mental illness towards the police force.

Most people with mental illness don’t commit crimes, but when people with a mental illness do come into contact with the police, it is frequently in the following circumstances:

- police are called in a crisis situation where family or carers are no longer able to contain a situation themselves
- police are called if members of the public interpret the symptoms of mental illness as being dangerous
- mental health services request police assistance if they are having difficulty dealing with a person in crisis
- a person is taken into custody for committing a minor infringement or misdemeanour.
Many individuals who come into contact with police do so because they haven’t had access to timely treatment, community support, housing, education or employment. There is a concerning regularity to police intervention eventuating in place of other supports, and as a result, too many people with mental illness are coming into contact with the justice system.

Research carried out through a collaboration between Monash University’s Centre for Forensic Behavioural Science, Forensicare and Victoria Police found that in a sample of 613 people taken into police custody, more than half had some contact with the mental health system. The psychosis rate within this sample was 6.2 per cent compared with 0.7 per cent in the general community in Victoria.¹

These findings are part of a broader research project, funded by the Australian Research Council and led by Professor James Olgoff, to examine the nature, purpose and outcome of police contacts with people who are mentally ill, and includes interviews with police to explore their experiences with mentally ill people. The findings will be used to develop a best practice model for discussion. This genuine attempt to improve understanding between mental health practitioners, consumers and the police gives me cause to hope that we will be able to build partnerships in order to better respond to the needs of people with mental illness.

**The need for improved police training is well established**

Following the fatal shooting of a 15-year-old boy in a Melbourne skate park in 2008, the Victorian Police Corporate Management Risk Division commissioned an examination of police shooting critical incidents, which had occurred between July 2005 and December 2008. Of the eleven police shootings that occurred during that time, in every case, mental impairment, mental illness, and drugs or alcohol, was prevalent.²

In 2010, researchers in the Centre for Forensic Behavioural Science at Monash University, found that of the 48 fatal police shootings in Victoria between 1982 and 2007, 87 per cent of victims had schizophrenia and other severe mental illnesses.³

Three years before the death of Tyler Cassidy in Melbourne, the Office of Police Integrity (OPI) had recommended that Victorian police officers be better trained to identify and manage people demonstrating signs of mental illness, through methods other than the use of force.⁴ In 2009, the OPI found that little had been done to address this recommendation, reporting in its key findings:

*Since June 2006, Operational Safety Tactics training has not focused on mental health issues or making sure police have the crucial skills required by police to identify and take appropriate action when someone may have a mental health problem.*⁵

In its 2006 report to the Victorian Government, the Boston Consulting Group also identified a need for police to be provided with specific mental health related training to improve their capacity to respond to psychiatric crises and divert people into mental health care rather than responding with arrests.⁶

**Mental Illness Fellowship Victoria justice policy**

Mental Illness Fellowship Victoria has recently ratified a policy that sets the framework for our advocacy to improve the experience of people with a mental illness coming into contact with the justice system in Victoria. Improving the capacity of police to understand and manage the challenging needs of a person with a mental illness in appropriate ways, without the use of lethal force, is one of our key advocacy priorities.
Improving police training is not simply a case of increasing the hours of training. The training must provide police officers with the real-life experience, skills and confidence to communicate with people who are distressed and vulnerable, resolve conflict, recognise symptoms of mental illness and refer people into appropriate care.

Consumers, carers and families need to be part of this training, and police officers should be given the chance to meet with people with mental illness during times other than crises. Basic training should be undertaken by all police, with additional top-up training for senior operational police.

At the same time, partnerships are needed between police and other services and community supports, to provide police officers with pathways to care for people with mental illness, other than through the criminal justice system. The relationship between Crisis Assessment and Treatment Teams (CATTs) and the police also needs to be strengthened so that the specialist knowledge of CATTs can be accessed when necessary.

Our policy position also calls for a review of police protocols in relation to on-the-ground policing when police are in contact with people with mental illness.

The Memphis CIT model

A few years ago I was fortunate enough to spend some time with the Memphis Police Crisis Intervention Team (CIT). The model of police training, staffing and crisis response developed within this team is now recognised internationally as highly successful and has been replicated in other cities, including Sydney, which has replicated a variance of the model. Between 15 and 20 per cent of the entire Memphis Police Patrol Division is trained to work with people with mental illness in crisis situations. These trained officers assume the leadership role in crisis events. The fundamental elements of the training undergone by these officers involves helping police to understand the effect that their behaviour can have on escalating or de-escalating the behaviour of a person with a mental illness, stressing the interconnectedness between consumer safety and police officer safety, and providing real-life exchanges between police and people with mental illness.

As part of their training, the Memphis officers visit psychiatric hospitals and the homes of people with mental illness, and undertake nine hours of role playing. Mental health workers are taken out in police cars to improve their appreciation of the environment in which police officers are operating.

The CIT model has resulted in faster crisis response times, a higher number of referrals to emergency health care outside the criminal justice system, decreased officer injury rates, and increased police officer confidence in responding to mental health emergencies'. A change to emergency departments in managing psychiatric crises has been an important part of these developments.

Joining up mental health and justice services

In Victoria, there is a growing recognition of the need for the mental health sector, government agencies, and the police to work together to divert people with mental illness from the criminal justice system into appropriate care, and also to improve the mental health care of people in prison and upon release from prison.

The Victorian Government’s Justice Mental Health Partnership Group includes wide representation from the justice and mental health systems, including Police Officers, Magistrates, Judges, representatives of child protection services and representatives of mental health services, agencies and forensic facilities. The group is working on developing high-level, coordinated processes in order to improve the health outcomes of people with mental illness in prisons or with a forensic history. This is a priority of the Victorian Government’s Victorian Mental Health Reform Strategy 2009-2019

Indeed, 24-hour access to mental health care facilities and partnerships with support services, have been identified as key to the success of the Memphis CIT model.

Investing in community-based services

When people with mental illness become part of the criminal justice system, it is, to a large extent, evidence of the under-resourcing of community-based and case management services for people with mental illness.

Greater investment is needed at the community level to help avoid the huge resources that are expended during times of crisis. We need greater investment in housing, employment services and recovery-focussed services. People with mental
illness live 90 per cent of their lives in their communities. Investment to secure community tenure is essential to improve mental health outcomes.

Despite this, there continues to be a major deficit at the front end of the mental health system. Many people with mental illness go without diagnosis or without access to services, or they are unable to maintain their treatment due to lack of stable and suitable accommodation. When people drop out of treatment, or become acutely ill, they are at greater risk of coming into contact with the police and the criminal justice system.

Positive police intervention

Positive interactions between police and people with mental illness lead to better mental health outcomes and contribute to community safety. Poor interactions lead to mistrust, fear, anxiety, and stories that people remember and tell for years, perpetuating the fear and mistrust, even though police approaches might have changed significantly since the initial experience.

Where families have had negative interactions with police, they are more likely to delay calling for police attendance until a crisis has reached a point of danger. Earlier police intervention, on the other hand, occurs when people have the confidence and the trust to request police assistance. Earlier intervention changes the environment of police presence from one of terror and anxiety, to a managed intervention, increasing the confidence of police to be able to deliver better results, and the likelihood of more timely calls for assistance in the future.

Police have a crucial role to play in the task of protecting the community during mental health crises. Through training and partnerships with mental health service providers, they can also play a crucial role in the equally important task of getting people into the care they need and on the road to recovery.

References

2 Reported in Office of Police Integrity (July 2009) Review of the use of force by and against Victorian police, p 24
4 Office of Police Integrity (2005) Review of fatal shootings by Victoria Police
5 Office of Police Integrity (July 2007) Review of the use of force by and against Victorian police, p 14
8 Victorian Department of Human Services (February 2009) Victorian Mental Health Reform Strategy, p 97
Peace of mind: implementing the Victoria Police Mental Health Strategy

Eva Perez, Mental Health Strategy project, Operations Coordination Department, Victoria Police

Police see the effects of mental illness on individuals and communities every day and know that they can impact greatly on how safe, supported and included people feel. Police routinely interact with people who have a mental illness or with people who are victims, witnesses, suspects, or in need of assistance.

The following statistics indicate the relevance of mental health issues for police service delivery:

- fifty-three per cent of people detained in police cells have a public mental health record
- on average, police refer 500 people in crisis to mental health services each month
- around sixty-six per cent of people taken by police to emergency departments are mental health patients
- around half of missing persons have a mental illness and around 20 per cent of them are reported missing from a mental health service
- at least eleven per cent of family violence reports identify mental health risk factors as present in one of the parties involved
- international research shows that people with a mental disorder are over-represented as victims of violent crime, sexual assault and personal theft
- police undertake around 500 coronial investigations each year into suspected suicides.

Responding to mental health needs therefore forms part of the prevention, early intervention, crisis intervention, law enforcement, public safety and support of other agencies’ roles that police perform. This diversity of interactions presents both challenges and opportunities for police. The challenges include:

- responding to unpredictable and often violent behaviour
- maintaining safety in situations involving multiple risks, such as a mental health crises, drug or alcohol use, and the presence of a weapon
- avoiding the inappropriate use of:
  - police members, e.g. conducting welfare checks or detaining a person for prolonged periods while awaiting assessment
  - police vehicles, e.g. using divisional vans to transport a person in a mental health crisis to hospital where there are no safety concerns
  - police facilities, e.g. using cells or interview rooms to detain a person awaiting assessment where there are no safety concerns
• having to make critical decisions without access to available information and expertise
• identifying the appropriate referral agency within a complex service system
• accessing services that have limited hours of operation, limited geographic coverage, high thresholds for access to service, or lengthy response times to police referrals.

The opportunities include:
• intervening to prevent a person in a mental health crisis from harming (or further harming) themselves or others
• linking people who have undiagnosed, untreated or unsupported mental health needs with appropriate services
• identifying people whose mental health issues are contributing to, or being exacerbated by, other problems such as their substance use
• contributing police experience and expertise in managing risk.

Victoria Police has policies, procedures and partnerships in place to enable these interactions and continues to build on them through its implementation of the Victoria Police Mental Health Strategy.

Victoria Police produced its Strategy in April 2007 following extensive consultation with police across the state, as well as community groups, service providers, partner agencies, consumers and carers. The Strategy encompasses people with, or affected by, mental illness, intellectual disability, acquired brain injury, personality disorder and neurological disorder, as it focuses on behaviours rather than diagnoses.

The Strategy includes 60 directions for improving police knowledge and information, strengthening internal and external partnerships, and updating police training. Implementation is almost complete and key initiatives implemented under these directions are:

Improving knowledge and information
• Created and maintained a Mental Health and Disability Knowledge Bank on the Victoria Police intranet to provide police with a central hub for information on state and local protocols, local initiatives, accessing specialised services, practice guides and answers to frequently asked questions, statistics and research.
• Created a flag for mental disorder on the central police database (LEAP) that provides authorised police and the 000-call dispatchers with limited information on a person’s triggers and typical behaviours, effective communication strategies, known risks, contact person, other mental disorder-related information (e.g., treatment orders) and the source of the information. In response to requests from a number of consumers and carers, Victoria Police policy now enables a consumer, their parent or their guardian to volunteer information for a flag to assist with any future police response.
• Introduced a Mental Disorder Transfer Form to facilitate the referral by police of people to mental health and disability support services. Police document on this form how the person presented while in crisis, in order to inform the clinical assessment and any future police response.
• Revised the policies and procedures in the Victoria Police Manual and the Department of Health and Victoria Police Protocol for Mental Health to make clear the roles, responsibilities and responses of each emergency service when assisting people in need. Victoria Police is currently working with the Department of Human Services on the first Protocol for Disability Services.
• Revised the procedures for investigating missing person reports so that mental disorder is part of the risk assessment checklist.
Strengthening partnerships

• Established an Expert Advisory Panel of senior representatives from Victoria Police, partner agencies, community services and consumers that meets quarterly to endorse initiatives developed under the Strategy, provide advice on improving policing services and notify Victoria Police of opportunities to work with others.

• Created a network of 120 Mental Health and Disability Liaison Officers across the state as an identifiable local contact for other police and people in the community, to provide information and advice on policing responses to mental health issues.

• Established regular reporting between the 21 local liaison committees and the statewide Inter-Departmental Liaison Committee on service delivery issues and improvements. Both levels of committee comprise police, mental health, hospital, ambulance, consumer and carer representatives.

• Trialling different ways of responding to mental health issues in the community. For example, there is a trial in a southern metropolitan police division of a Police, Ambulance and Clinical Early Response (PACER) model. The model involves a vehicle staffed with a police member and a mental health clinician responding to situations where frontline police or ambulance paramedics believe mental health issues are present. The PACER unit provides prompt onsite clinical assessments, refers to a broad range of services, develops multi-agency intervention plans for frequent presenters, avoids unnecessary transport to hospital, and advises on de-escalation techniques and options for response. The trial ends in August 2011 and is being independently evaluated.

• Participating in a five-year research collaboration with Forensicare and Monash University (Project PRIMeD) on aspects of policing and mental disorder. The 13 studies underway are examining the symptoms of people detained in police cells, police knowledge of, and attitudes to, mental illness and the use of force and data analysis from the Mental Disorder Transfer Form. Victoria Police is using the findings from the research to revise its policies, procedures and training.

• Contributing to systemic initiatives, such as the development and implementation of the Victorian Mental Health Reform Strategy and the re-write of the Mental Health Act 1986.

Updating training

• Recommended changes to the content and delivery of the Diploma of Public Safety (Policing) for recruits, updated the Reference Guide and course notes, and introduced a requirement for probationary constables to demonstrate their skills in referring a person in crisis to mental health services as part of their mandatory qualifying tasks.

• Created a new mental health module for the Operational Tactics and Safety refresher training that all frontline police must undertake each six months. This four-hour module comprised scenarios, presentations by experts, role-playing, advice on communication strategies and sources of information and was delivered from January to June 2010. The July to December 2010 cycle built on this module with a session on acute behavioural disturbance. Planning is underway for modules on other aspects of policing responses to mental health issues for future cycles.

• Revised the module on recognising and responding to cognitive impairment delivered to detectives as part of the Sexual Offences and Child Abuse Investigation Team course.

• Accredited ten employees to deliver the two-day Mental Health First Aid course on recognising and understanding different forms of mental illness. To date, 84 courses have been run across the state to more than 1220 employees who volunteer to attend. Work is underway to run joint courses with the Metropolitan Fire Brigade and Ambulance Services Victoria.

• Funded Applied Suicide Intervention Skills Training for 120 police, peer support officers and a number of other police members across the state.

• Trialled an online program on Suicide Awareness, Substance Use and Mental Health in partnership with a tertiary education provider.

Victoria Police is committed to continually reviewing and updating its policy, practice and training, and welcomes any feedback or advice on areas requiring attention.
Mental health and transition from prison to the community

Paul Atkinson, Senior Project Officer, Victorian Association for the Care and Resettlement of Offenders (VACRO)

We assist our clients by providing intensive support programs and managing issues associated with mental health, as part of a cluster of, often, interconnected issues facing prisoners on release. Poor mental health, homelessness, drug and alcohol dependence, acquired brain injuries, gambling, poverty, low levels of education and limited work histories are some of the many issues facing prisoners and all have the potential to impact substantially on post-prison outcomes.

In 2000, the Victorian Association for the Care and Resettlement of Offenders (VACRO) published an article by Grant Curran about transition from prison. Grant called it ‘Post Prison Madness’. Drawing on his personal experience, Grant explained the social and emotional process of getting out of prison.

His list of challenges included isolation, dislocation, fear and paranoia. He talked about the ‘overwhelming sense of not belonging’ and the strong desire to ‘lock yourself away in your house, flat or room, because it is what you are used to’. He also wrote about bursting into tears at random and the trouble distinguishing the real from the unreal. Grant also posed, rhetorically, the question facing many ex-prisoners: ‘how do you explain to a doctor or counsellor about an adult whose survival skills are only appropriate to a life in prison?’

Grant explained that ‘you are not, and never will be, the same person who went to prison’, and talked of the ramifications this has on the ex-prisoner’s relationships. He also talked about the unrealistic expectations prisoners have of their partners as well as the difficulty they face returning home to a new set of responsibilities, or the chaos of children’s toys and noise.

VACRO provides a range of services for people leaving prison. We work in two consortia to provide case-managed transitional support for men and women leaving prison and have another support program for serious and persistent offenders. VACRO also provides a number of other small programs that assist people in prison, such as our prisoner property and banking service. Women exiting prison are able to join a volunteer mentoring program that supports them as they reintegrate into the community. We work with families of offenders, acknowledging the difficulties associated with having a loved one incarcerated and the important role families invariably play upon release from prison.

Our approach to working with prisoners is informed by the stories of people like Grant Curran and nearly 140 years of working in Victoria’s prison system. We assist our clients by providing intensive support programs and managing issues associated with mental health as part of a cluster of often, interconnected issues facing prisoners on release. Poor mental health, homelessness, drug and alcohol dependence, acquired brain injuries, gambling, poverty, low levels of education and limited work histories are some of the many issues facing prisoners and all have the potential to impact substantially on post-prison outcomes.
Beyond our intensive support programs, we also work with current and former prisoners, such as Silvio*, who is currently participating in Second Chance Cycles, a VACRO-run bicycle workshop. He is one of several prisoners participating in day leave from prison – an opportunity open to inmates at the end of their sentence. When I first met Silvio, he was elbow deep in grease, replacing the derailleur on an old road bike. Rigged up on a stand, the bike, stolen and unclaimed, had spent the last few years rusting away in a container at a police depot, amongst an assortment of other makes and models.

VACRO’s programs such as Second Chance Cycles provide opportunities for people to engage in a shared activity with others, supporting them to connect with people in a safe space while learning new skills. Clients are able to follow through with accredited training and work placements.

Silvio has gained confidence and workplace competence at the bike workshop surprisingly quickly, transferring skills he picked up whilst working in the prison industry. Like most prisoners however, the proficiencies he has accumulated from his time in prison remain unaccredited and his résumé is dauntingly sparse. Statistics show that in 2010, nearly ninety-five per cent of prisoners had not completed secondary school. There are only a handful of prisoners with tertiary qualifications (not even two per cent in 2010) and even less with trade qualifications: between one and six people in each of the last five years.

In a few weeks, Silvio is due for release on Parole and will re-enter a community he has known only in fits and starts as an adult and one that changes rapidly. He is long past the age where indiscretions can be passed off as youthful and, like many prisoners, his post-prison prospects are limited. He will face strict Parole conditions and harsh sanctions for any breaches on account of his history. It is fortuitous that he now has age on his side, being older, more experienced and calmer.

Like many prisoners, Silvio has a son, now eleven years old, who is waiting for him as he transitions from prison. A 2001 study put the figure of children of prisoners at over 38,000 Australia wide, a number presumably rising with the Australia-wide expansion of prison capacity. In contrast to the majority of the other fathers in prison, Silvio is likely to resume the role of primary carer of his son, something he took on after his partner passed away in 2005.

VACRO has held a long-standing concern for the children of imprisoned parents. Although this issue has been discussed for at least thirty years in Australia, the response to these ‘invisible victims’ of crime requires further development.

During Silvio’s recent stint in prison, his sister-in-law assumed responsibility for his son. The family is now facing yet another critical point of transition. VACRO has a children’s counsellor who is assisting Silvio with his parenting role. Silvio has been able to develop and enact a family reintegration plan in a safe space where he can explore and manage his anxiety and fear.

Children with imprisoned parents are reported to experience elevated levels of anxiety, shame, grief, isolation and guilt, have lower self-esteem and report having poorer relationships with their peers. Although some of this relates to pre-existing disadvantage, there are credible suggestions that parental imprisonment has such a severe impact on child development that it can damage mental and physical health.

Having a child is a double-edged sword for prisoners. It can be a blend of burden, anxiety, motivation and hope that is difficult to synthesise. Prisoners often see their release as a perfect time to set things straight and make amends for failed relationships. Some spend years in isolation imagining how things could be and mentally playing out a return that may not happen within a family that has long since moved on.

Silvio is under no illusions about getting out and getting back to his family, perhaps because he has been through it too many times before. He is fortunate to have been given an opportunity to go through a transitional process, which includes gradually increasing day releases. Although he has missed some important years in his son’s life, during an age when children rapidly change their friends and interests and understanding, he is approaching the situation with a cautious optimism that appears to be working.

According to Grant Curran, after a long-term imprisonment, ‘the last thing you want people to do is tell you that what you are feeling is “normal” because it doesn’t feel normal. What you do need is pre-release and post-release programs directed towards prisoners and their families and focused on relationships, developing coping and survival skills and ensuring the prisoner has every chance of remaining in, and feeling part of, the community’.

---

*Silvio is a pseudonym to protect his identity.
Prisoners are a heterogeneous group with different interests and goals and connecting ex-prisoners to their community is far from straightforward. VACRO delivers a case-management model that assists people to develop a pre-release plan, starting up to three months before release. Case managers are then able to provide the necessary links and resources post release, for the plans to be successfully implemented. At Second Chance Cycles we work with people like Silvio to develop and demonstrate a skill of value to them and the community. Silvio is currently working through a set of modules with trained bike mechanics that we hope will lead to him enrolling in the Certificate II in Bicycle Mechanics. He has also restored a number of bikes that have been donated to the community.

Understanding the prevalence of mental health in prison is complicated. We do know that people with mental health issues—diagnosed and probably undiagnosed as well—are over represented at all stages of contact with the criminal justice system, including police, courts, prisons and community corrections. Where substance abuse commonly occurs with mental illness, it is not surprising that conflict with the law can easily follow. People with multiple and complex needs may have limited access to mainstream health and social supports to maintain stability in the community. The resulting cycles of unstable behaviour attracts the attention of the criminal justice system.

The Victorian Department of Justice has acknowledged the need to address the ‘significant number of people’ with mental health conditions who ‘cycle through prisons’ with the release of the Justice Mental Health Strategy in 2010.

VACRO’s approach focuses on people’s social and emotional wellbeing and relationships. We provide support around basic needs for material aid and housing, as well as links to specialist services tailored to meet the needs of the individual. Beyond that, our holistic approach means that we work to create opportunities for people to rebuild important family and social connections and engage in recreation and meaningful vocational pathways. Working in parallel with specialists, such as mental health providers and drug and alcohol clinicians, we work to deliver a holistic response to support each person’s access to the services and relationships they need for stability in the community.

References

* Names and certain details altered to protect identity.

"Second Chance Cycles", VACRO's community bike workshop. Photos courtesy of INCE
Lighting the match: consumer participation at Forensicare

Julie Dempsey, Forensicare Consumer Consultant, Thomas Embling Hospital

It is the responsibility of staff to encourage and support consumer participation so that it becomes a dynamic exchange, resulting in increased growth and understanding for all parties.

The Victorian Institute of Forensic Mental Health, commonly known as Forensicare, is the key provider and coordinator of adult forensic mental health services within Victoria. This includes providing services at Thomas Embling Hospital (TEH), Community-Based Forensic Mental Health Services (CFMHS), and involvement in Prison Services including the Acute Assessment Unit at Melbourne Assessment Prison and Marrmak Unit for women at the Dame Phyllis Frost Centre. Forensicare employs four consumer consultants to cover this broad umbrella of programs, however I will be concentrating on consumer participation at TEH as this is my main area of focus.

Thomas Embling Hospital is a 116-bed secure facility catering generally for three types of patient groups:

- **Security patients** come across from prison in need of acute care for their mental health issues
- **Forensic patients** are deemed not guilty due to mental impairment, but in need of treatment and rehabilitation in a custodial setting
- **Involuntary patients**, detained under Section 12 of The Mental Health Act 1986, are in need of a secure forensic setting to safely manage their mental illness.

At first glance one may think that TEH would be more restrictive than Area Mental Health Services when it comes to enabling consumer participation. On the contrary, there is an extensive consumer participation program in place facilitated by two part-time consumer consultants, and supported well by other disciplines, particularly Allied Health, and a progressive Management Team.

Forensicare acknowledges the principle that patients have a fundamental right to be involved in their treatment and care as stated by the World Health Organisation: “People have the right and duty to participate individually and collectively in the
planning and implementation of their health care’ (WHO, 1978). I will give examples later how Forensicare does this on both an organisational and individual level.

The above quote assumes a willingness and ability to participate in treatment. In mental health, treatment can be given involuntarily and often works on the assumption that the patient cannot, at least initially, participate constructively in their own treatment. Symptoms such as lack of insight, impaired judgement, diminished capacity, separation from reality, withdrawal, reduced motivation etc. can result in the justification of involuntary treatment.

It is because of this clash of views as to what constitutes reality and societal views of acceptable behaviour, that consumer input is not only critical in improving service delivery but is a very emotive and passionate area to be involved in. So the process needs to be collaborative, respectful, and engaging for all parties. It is ‘a process of quality improvement for service delivery that increases consumer satisfaction through consumers having the opportunity to be influential in the decision making process across policy and development, including training and evaluation’ (DHS, 1996), with the aim of investigating ‘improvement activities that consider clinical, social, emotional and cultural aspects of care and service’ (The Victorian Quality Council, 2003).

It is the responsibility of staff to encourage and support consumer participation so that it becomes a dynamic exchange, resulting in increased growth and understanding for all parties.

‘Real consumer participation is not just inviting the match to sit beside the matchbox; it’s getting the match and matchbox to interact so they will make something new: fire’ (Mary O’Hagan, 1994).

The dangers of being tokenistic and just ticking the boxes can have negative consequences such as ineffective service delivery and deterioration in consumer participants’ mental health and willingness to engage. A typical example of this is when a consumer is invited to be on a working group or committee but is not given the opportunity to express his/her views. Consumers should be encouraged to speak up and asked directly what their thoughts are on what is being discussed.

In these situations, the consumer is often in a room full of staff, which can be intimidating as it is not always easy for consumers to speak up or for staff to hear what they are saying. I personally think that if a consumer is involved in a meeting, it is the responsibility of the chair of that meeting to check in with the consumer afterwards to see how they are travelling. This process needs to be respectful and staff also need to be reminded that the consumer can be coming from a vulnerable position.

Consumer consultants can also support patients in meetings or through debriefing sessions after meetings if necessary. It takes courage for patients to put themselves out there and fortunately at Forensicare, in my experience, staff encourage patients to be active in parts of their treatment and challenge them in a positive way to grow within the system, even to the point of changing the system.

For example, one of the Occupational Therapists organised a group You Are What You Eat to be planned, delivered and co-facilitated by patients on the unit. The end result was that by having patient input into the development of the group and co-facilitating, there was a more consistent and enthusiastic attendance. As weight gain is an important issue for mental health patients, this was an inclusive way of getting them to look at how food and exercise can determine their physical wellbeing.
Although it may have been confronting at first for the patient co-facilitators, the resulting self-esteem, sense of achievement, confidence, and inclusion in therapy was a good reward. Relating to Mary O’Hagan’s quote on ‘making fire’, the outcome was so positive that the occupational therapist is now working with patients and the consumer consultants to develop a training manual so that others can replicate their success in other parts of the hospital.

Part of being looked after in hospital is the unsaid surrender of your usual autonomy and self-determination. Rules can be put in place as necessary risk management and protection of people and property. However, some patients may see these same rules as controlling and dehumanising. What staff may perceive as a therapeutic relationship can, to the consumer, feel like a power, or lack thereof, set up in the eyes of the patient.

As work in mental health often comes from a kind heart, it is unfortunate that receiving treatment can sometimes result in a perceived loss of dignity for patients. By encouraging consumer input, some of the sting of being in a restrictive environment is taken out so that patients can focus on positives and strengths, thus becoming more pivotal in their own recovery.

One example of consumers becoming more involved in their own treatment and working collaboratively with staff is a pilot project in one of the acute units at TEH. The project involved patients, clinical staff, the Nurse Unit Manager, the Quality Manager, and was partly facilitated by a consumer consultant. As a result, certain patients will now be invited to attend part of their clinical review. This concept has been viewed positively by both staff and patients in its implementation.

The result has been the opportunity for more direct communication by both parties in patients’ treatment, working together to overcome present difficulties and growth of cooperative outcomes. This can even flow on to mean a more settled unit, due to fewer disgruntled patients and the absence of the ‘us and them’ mentality translating into less aggression and incidents.

Individually, consumer consultants can also act as mentors and lead by example to other consumers that a diagnosis of mental illness does not have to mean the end of the world and life as you have known it. Consumer consultants also support other consumers to take an active role in their treatment and conditions whilst building dignity and hope. A recent example was changes being introduced to the property patients who were to be allowed in their rooms.

Through the Consumer Advisory Group (CAG) and follow-ups by the consumer consultants, a compromise was reached regarding the final formulation of the Patient Property Policy. Although the patients did not get everything they wanted, they, at least, felt consulted and heard on the issues and were happier with the final outcome.

When navigating the sometimes turbulent waters between consumers and staff, the consumer consultants can go to the CAG, management and the Consumer Participation Reference Group for consultation. The Consumer Participation Reference Group is an essential part of our framework, providing an opportunity to meet with managers to discuss issues, initiatives and provide feedback about our work. To me, this reflects how supportive, committed and respectful Forensicare is about consumer participation.

Our CAG is made up of one patient representative from each of the seven units at TEH, ranging from Acute Units, Continuing Care Units, to the Rehabilitation Units. There is also a sustainability representative to encourage a responsible environment focus around the hospital, a food representative, and a transition representative who attends both the Community Forensic Mental Health Service, the CAG and TEH CAG. The transition representative position was created to build better bridges between the services, particularly highlighting obstacles faced by patients reintegrating back into the community after many years at TEH.

While the CAG is facilitated by the consumer consultants, part of being a representative on CAG comes with certain responsibilities: To be an approachable point of contact for consumers, talk to fellow consumers to ascertain views, represent these views impartially at the CAG meetings, forums, and committees where required, attend community meetings for staff and patients, raise issues with the Nurse Unit Manager where appropriate, offer possible solutions to issues raised in improving service delivery, and provide feedback to consumers on the CAG’s activities. Consumers are reimbursed for their time and commitment.
A lot of consumer responses can be viewed as purely reactive and this is an important part of our work. However, we are also committed to progressive action such as capacity building and project initiatives, e.g. consumer representatives on the Obesity Committee and Special Events Committee, development of the Medication Questions Brochure to assist patients when talking to staff about their treatment, and the Water Coolers Submission to encourage consumption of water in units instead of coffee and soft drinks.

The CAG also holds collaborative forums for staff and patients to attend together to discuss issues in an open environment. In 2010, guest speakers spoke on faith and spirituality to break down barriers and broaden knowledge on Christianity, Islam and Buddhism religions. The Chief Psychiatrist, Dr Ruth Vine, also delivered a session on the Role of the Chief Psychiatrist’s Office.

Our latest accomplishment has been extensive consumer involvement in making the DVD: *Introduction to Thomas Embling Hospital*, targeted at future patients, new staff, families and carers. The ideas behind the DVD were to allay fears of people new to the hospital about any ‘One Flew Over the Cuckoo’s Nest’ type preconceptions they might have, and attempt to take the stress out of a transfer from prison to an unknown place.

### Summing up

When staff are welcoming and respectful, consumers can really thrive in an environment that might otherwise be intimidating.

Consulting with consumers taps into a wealth of experience and on-the-ground knowledge regarding the service they are involved in. Their role can change from merely being a recipient of the service, to that of an active participant, resulting in: empowerment of the individual, a regained sense of respect for themselves and workers, and an outlook of being actively engaged in their own treatment.

This means more than just compliance. It is about seeing life and the current situation as worthwhile and with ongoing purpose. It offers hope. With hope comes motivation, which can be hard to muster at times. Consumer participation is a process, not just an end product.

For the service to have effective informed service delivery, continued acknowledgement and use of consumer input across the service is vital. Consumers are real people, with real insights and real feelings. I believe Forensicare’s comprehensive Consumer Participation Program addresses this well within its working parameters and is always reviewing how to best meet the needs of those in its care.

### References

- The Victorian Quality Council (2003) Enabling the consumer role in clinical governance – A guide for health services (supplementary paper to the VQC document Better Quality, Better Health Care)

The Consumer Participation Reference Group is an essential part of our framework, providing an opportunity to meet with managers to discuss issues, initiatives and provide feedback about our work. To me, this reflects how supportive, committed and respectful Forensicare is about consumer participation.
Bundji Bundji – supporting Indigenous young people in the justice system

Freda Haylett, Evaluation Officer, Whitelion Community Care

The fact remains that the structure of the health system can be extremely intimidating to the young people and runs the risk of exacerbating current mental health issues if not dealt with in a culturally sensitive way. Bundji Bundji has found that providing an Aboriginal facilitator to assist the young people in navigating the mental health system can lead to more successful outcomes.

Background

Bundji Bundji is a partnership between Whitelion and Narana Community Care. The partnership was formed in May 2006 in response to the overrepresentation of Indigenous young people in the youth justice system. There is a strong belief in the Indigenous community that the justice system is not working for Koori young people, but rather privileges the mainstream. Therefore, it is the aim of Bundji Bundji to provide support to Indigenous young people who are marginalised by having the uniquely difficult challenge of facing the justice system.

Under the umbrella of Bundji Bundji are two subsequent programs: the Northern Bundji Bundji Project, a voluntary outreach service for young Indigenous men that began in 2006 and the recently formed Tiddas Program that provides similar support for Indigenous young women.

The Bundji Bundji Program objectives are to:
• assist Koori young people to stay in school or employment and to reconnect with community
• link the young people into local services
• promote healthy, positive lifestyle choices through recreational programs such as cultural camps and art programs
• utilise the leadership of Elders and young people who can act as role models to guide at-risk young people
• reduce the extent and incidence of antisocial and criminal behavior in young people through diversions that provide meaningful alternatives to offending.
Mental health

Mental health is not formally dealt with by Bundji Bundji, but is a significant underlying issue. Factors such as substance abuse, family breakdown, grief and loss, intergenerational trauma and discrimination—particularly in the education system—have resulted in a loss of clarity and direction for a lot of the young people Bundji Bundji supports. Intergenerational factors are particularly crucial in understanding the challenges faced by these young people. Research supports this assertion, revealing that Indigenous children whose mothers were forcibly separated from their natural families are two and a half times more likely to be at risk of ‘clinically significant emotional or behavioural difficulties’.

Bundji Bundji supports clients whose suspected mental health concerns have been alleviated by taking a more holistic, culturally sensitive approach to the client’s recovery, rather than just relying on clinical practitioners as the primary method of treatment. Simple, practical solutions that reduce the complexities in the young people’s lives can, at times, prove most effective in reducing stress and anxiety. For example, Bundji Bundji’s young clients sometimes receive requests for information from services that ask them to provide means of identification such as a birth certificate or a Medicare card. Unsurprisingly, due to the chaos many of the young people experience in their daily lives, a birth certificate might have been misplaced some time ago. Bundji Bundji can provide the young people with a new birth certificate; a small gesture of support, but it nevertheless simplifies an aspect of the young person’s life. Sorting through some of the more minor complications has allowed a number of the young people to get to a place where they feel more capable of receiving clinical help if needed.

In the cases where a medical intervention has been deemed appropriate for a Bundji Bundji client, there are instances where referring the young person with mental health concerns to a clinical practitioner without a culturally appropriate mediator in place can be counterproductive. A 2008 review of the social and emotional wellbeing of Indigenous Australians published in the Australian Indigenous Health Bulletin, found that there was ‘a lack of culturally appropriate services, and a lack of Indigenous staff within available services’ consequently having an adverse impact on Indigenous people accessing support services. The fact remains that the structure of the health system can be extremely intimidating to the young people and runs the risk of exacerbating current mental health issues if not dealt with in a culturally sensitive way. Bundji Bundji has found that providing an Aboriginal facilitator to assist the young people in navigating the mental health system can lead to more successful outcomes.

Bundji Bundji’s outreach workers often involve the families of clients in the support they provide. This approach has been identified as an effective component in assisting young people with a mental illness in the report Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. The report states that working with the families as a team and providing practical advice to family members are among the many things that workers can do to enable a greater understanding of mental illness amongst families in the community. Bundji Bundji Outreach Worker Uncle Lester Green took a whole-of-family approach that really resonated with the young people and this was evident in an evaluation of the program. One young person recalled that Uncle Lester ‘told him [the father] my side of the story’, which had been a significant moment in that particular young person’s ability to reconnect with their dad.
Intergenerational factors are particularly crucial in understanding the challenges faced by these young people. Research supports this assertion, revealing that Indigenous children, whose mothers were forcibly separated from their natural families, are two and a half times more likely to be at risk of ‘clinically significant emotional or behavioural difficulties’.

Furthermore, Bundji Bundji has seen positive results from taking a more holistic, spiritual approach to mental health. A few of Bundji Bundji’s clients have been referred to cultural healing centres in Melbourne and Echuca. As a result of long-term culturally appropriate placements that build trust, the young men have commenced clinical assistance to address long-term grief and loss issues that have had enormous impact on their lives and played a major part in their ongoing involvement with the criminal justice system.

Case study

Josh* is an 18-year-old client of Bundji Bundji who has been involved with the Bundji Bundji Program for more than three years. He initially accessed the program through Bundji Bundji Elder Uncle Lester Green who provided advocacy for Josh in the justice system. Josh was using substances, mostly cannabis and alcohol, which led to involvement in crime. The program provided culturally appropriate support and advocacy within the justice system, and worked with Josh to address issues such as income support, fines, training and employment and reconnection to community through sport. The program also uses the stories of the workers and Elders to connect with young people and continues to support young people in a positive regard, as long as they continue to want the support of the program.

Josh continued to have issues around grief and loss and dealing with family concerns around substance use and violence. When he was able to sort out the issues in his life, the larger issues were coming to the forefront, where he could tackle them head on. Josh made a decision to place himself in a detox facility and then into a long-term rehabilitation facility. He continues to reside at the facility, is committed to the four-month program and has secured a position in landscaping when he finishes his rehabilitation. He is involved in counselling and has been able to move away from family and friends who encourage drug use. He feels that working with Aboriginal support workers in a program that is culturally aware has made a significant difference to his circumstances. The ability to be involved in decision making within the program and be at the centre of any discussions or decisions that involve him, have made a difference to his ability to make decisions for himself.

* Name has been changed.

References


Prisons and the perpetuation of disadvantage

Sam Biondo, Executive Officer

David Taylor, Policy Officer, Victorian Alcohol and Drug Association (VAADA)

There is a strong yet erroneous perception that the crime rate is constantly rising as well as an exaggerated notion of the prevalence of violent crime. There is little space in the mainstream public discourse for issues relating to disadvantage and the role prisons play in perpetuating the cycle of disadvantage or the type and extent of rehabilitative services linked to prisons. In general, this silence perpetuates many negative and ingrained problems associated with prisons.

This article discusses the costs of imprisonment in Australia and the collateral harm which it creates. It outlines some of the facts and figures related to imprisonment as well as some of the harms derived from this. This article does not have the scope to provide nuanced policies in response to the failures of the justice system, but will outline a way forward to responding to crime and the social determinants, which are often deep seated causative factors.

The Australian prison population is a small, diverse and isolated cohort, characterised by high levels of disadvantage across a range of issues such as high levels of mental illness, victimisation (including family violence), substance use and dependence issues, unemployment, limited education, limited access to housing and poor health. Prisoners, by virtue of these adverse social determinants and the social isolation they endure, both in prisons and in the community generally find it difficult to self-advocate and have limited access to avenues of public discourse. Interestingly, much of the research informing the general operation and evaluation of Australian prisons and those who frequent the prison system, does not relate to the lived experience of those likely to endure high levels of disadvantage, but rather refers to program outputs such as program completion, recidivism, escapes, deaths in custody, hours outside of cell, assaults in custody and prisoner employment and education. This approach to looking at prisons and their inmates, in part, drives penal policy and practice. In fact, this approach determines the ideological basis of prisoner identity to the point that: ‘rather than clients in need of support, they are seen as risks that must be managed’, (Garland, 2001).

The financial burden of running prisons

Crime costs the Australian government up to $19 billion per annum; of this, $10 billion is channelled into the development of prisons and policing. The daily average number of prisoners in Australia in mid-2010 was approximately 28,843. It is of great concern that the rate of reoffending within the first two years of release has gradually increased over the past five years to 39.3 per cent. Astoundingly, two out of every three prisoners has previously been incarcerated. Despite these failures, approximately $2.8 billion of public money is spent each year on maintaining and expanding the Australian prison
system. Yet this expenditure, irrespective of the long-term outcomes, draws little comment or query from either politicians or the public. Prisons, police and law and order policies appear to be viewed as an embedded necessity by the general community and largely beyond reproach. Prisoners are portrayed as ‘the other’ and seen as undeserving, wicked, violent and intractable. There is a strong yet erroneous perception that the crime rate is constantly rising as well as an exaggerated notion of the prevalence of violent crime. There is little space in the mainstream public discourse for issues relating to disadvantage and the role prisons play in perpetuating the cycle of disadvantage or the type and extent of rehabilitative services linked to prisons. In general, this silence perpetuates many negative and ingrained problems associated with prisons. Within the mental health environment many similarities could be drawn to the nature and impact of institutionalised mental health service delivery, which fortunately, in recent decades, has gradually taken on a series of transformative changes.

**A health and welfare diagnosis of prisoners in Australia**

Australia’s general prison population is characterised by a complex amalgam of social and health issues. As an insight into our prison system consider some of the following facts:

- 75 per cent have completed only up to year ten of schooling
- between seven and eight per cent of males and eleven per cent of women were homeless prior to imprisonment
- Aboriginal and Torres Strait Islander peoples are significantly overrepresented in prisons and generally experience more exacerbated adverse social determinants than other prisoners. For example, they are 13 times more likely to be imprisoned than other community members
- 37 per cent report that they have had a mental health disorder at some stage in their lives and 18 per cent are currently on medication for mental health related conditions
- 35 per cent have Hepatitis C (with higher rates for those who are injecting drug users).

Furthermore:

- prisoners are heavy consumers of both licit and illicit drugs with 81 per cent being current smokers (compared with 16.6 per cent of the general population)
- 52 per cent of prisoners reported that they drink alcohol at harmful levels, compared with 20.4 per cent of the general population
- 71 per cent of prisoners had used illicit drugs in the past 12 months, compared with 13 per cent in the general community.

Finally, prisoners are likely to also be victims of crime. This is particularly salient for female prisoners, who have often survived family violence and sexual assault. These women face a wide array of challenges, which is unique to their demographic and beyond the scope of this paper to cover in detail. Many of these challenges are discussed in the Drugs and Crime Prevention Committee’s Interim Report.

**Evidence that prisons exacerbate existing harm**

» **Suicide**

Suicide is a significant issue facing prisoners and ex-prisoners. The suicide rate amongst ex-prisoners within the first six months following release is three times higher than the general community. Likely to be contributing to this increase is the increased likelihood of heroin overdose for those who use after a period of abstinence.

» **Family breakdown**

Imprisonment often contributes to the breakdown of families, in particular when single mothers are incarcerated; approximately 80 per cent of women in Victorian prisons have children with the majority of them being sole parents. These women may find it difficult to be reunited with their children as suitable accommodation is often a factor in determining these cases. These circumstances often lead to a further spiral of dangerous behaviours and self-harm.

» **Housing**

There are inherent challenges facing ex-prisoners, as criminal records often create challenges in obtaining private rental, due to gaps in rental history. The housing sector also creates barriers to ex-prisoners obtaining public housing, which results in them being forced to reside in inappropriate and harmful abodes such as rooming houses and hostels, where they are often exposed to various elements that catalyse their likelihood of reoffending and undo any positive gains, which may have been achieved through various rehabilitation, treatment and support programs and activities.

» **Poor education and health**

There is a growing body of evidence, which highlights a relationship between education and health, noting that those with poor health tend to have limited education and vice versa. Research indicates that addressing the deficit in education will result in a greater level of awareness in good health practices and will also have a subsidiary positive effect on employment and, in turn, an impact on income, resulting in better access to accommodation.
The need for systemic change

The likelihood of returning to Court is greater for those who have more prior Court appearances. This is not to say that Courts are anti-therapeutic or cause crime, but rather that the system as a whole is not meeting the needs of those who frequent the Courts. For many people who are experiencing the myriad adverse social determinants detailed above, the criminal justice system provides the first comprehensive intervention and response to their challenges. Other, more therapeutic, interventions must be available to this cohort at an earlier stage. Director of NSW Bureau of Crime Statistics and Research Dr Don Weatherburn notes that those who start early in crime tend to remain involved and commit more serious offences as they get older.

As Weatherburn asserts, individuals who offend regularly over a long period of time, are more likely to come from low income families (with siblings who have also engaged with the justice system), have a lower IQ than average as well as mental health problems. They are also more likely to use licit and illicit substances at harmful levels. Developing and implementing evidence-based approaches to address crime would likely have the additional benefit of positively impacting upon those other harmful signifiers of disadvantage.

Solutions to address the causes rather than symptoms of crime

The first step to be taken is to provide a public space for sensible and reasoned discussion on evidence-based responses to law and order issues and to realise that adverse social determinants have a structural foundation, which must be acknowledged and cannot be addressed through individual sectors working in isolation. There is a need to question the mores, which provide the foundations that embed specific institutions into the social and political fabric of contemporary Australia, such as prisons. This needs to be undertaken with a view to revealing their iatrogenic and counter-productive aspects. For instance, an evaluation into the utility of prison as a suitable environment for those experiencing adverse health conditions, such as drug and alcohol addiction or mental illness, is a worthwhile endeavour. This evaluation would demand a comprehensive examination of the purposes of a prison and measure those purposes and practices against their achievements. A key function of this examination is the need to review the function and form of what prisons are expected to deliver or capable of delivering. Current policies of enlarging the prison system on the same basis as the past, are misdirected and contrary to reducing overall disadvantage in the long term. It is vital that we re-examine community-based approaches or whether more therapeutic approaches are in fact possible within the existing prison system.

The priorities governing the daily operations of prisons typically run contrary to the evidence-based approaches adopted by the many welfare sectors which provide support and assistance to individuals who experience adverse social determinants that are common amongst prisoners. Whether deliberate or otherwise, the sense of heightened danger and threat associated with prisoners, protects the ideological structures that maintain the status quo of prisons and continue to perpetuate the prioritisation and emphasis of security above all other welfare matters. This also contributes to protecting prisons from meaningful review and evaluation. It is crucial that these barriers are broken down and that review and evaluation be undertaken with due consideration given to the characteristics and adverse social determinants evident in the prison population. Access to, and involvement of, relevant welfare organisations must be given primacy in prison operations and planning and in the broader discourses on responding to the symptoms of disadvantage, which often manifest as law and order issues.

►►► VICSERV can provide this article with its full list of references. To request a copy, please contact Kristie Pate on 03 9519 7000 or k.pate@vicserv.org.au
The ARC List

Carrie O’Shea, Assessment and Referral Court (ARC) List Coordinator, Victoria Legal Aid

For clients who successfully complete an episode in the ARC List the benefits are clear. Achievements can range from maintaining abstinence from drugs and alcohol to reconnecting with family members or finding stable accommodation. Clients who have achieved such goals speak of being given a ‘second chance’ and are extremely grateful to the court for having been given the opportunity to participate.

Editor’s note

The Assessment and Referral Court List (the List) is a specialist court list developed by the Department of Justice and the Magistrates’ Court of Victoria to meet the needs of accused persons who have a mental illness and/or a cognitive impairment.

The List is located at Melbourne Magistrates’ Court and works collaboratively with the Court Integrated Services Program (CISP), which provides case management to participants. Case management may include psychological assessment, referral to welfare, health, mental health, disability, and/or housing services and/or drug and alcohol treatment.

This description has been reproduced from the following webpage: http://www.magistratescourt.vic.gov.au/wps/wcm/connect/justlib/magistrates+court/home/court+support+services/magistrates++assessment+and+referral+court+list (2010), State of Victoria, via the Magistrates’ Court of Victoria’s website.

Introduction

The Assessment and Referral Court (ARC) List commenced sitting at the Melbourne Magistrates’ Court on 21 April 2010. As the Coordinator of the Victoria Legal Aid (VLA) working within the List I have been actively involved with the court since its inception. Nearly a year into the pilot the court’s practices and procedures are now firmly established and a number of client’s have finalised their episodes in the List. It is, therefore, a good time to reflect on how the List is operating.

The role of VLA in the List

Victoria Legal Aid provides a duty lawyer service specifically for the court. VLA lawyers are present at each List sitting and have developed strong relationships with court staff. They have also completed training to learn about issues facing the List client group. Having these relationships and expertise ensures VLA lawyers are in a good position to represent clients and explain to them how the List operates. The dedicated service also ensures that the client sees the same lawyer every time they come to court.
Referrals

Referrals to the List have come from various sources including legal representatives, prosecutors, Magistrates and, in a small number of cases, service providers within the community (for example Disability Client Services). Experience has shown it is important that referrals are targeted at appropriate candidates. Because the List is voluntary, it is not appropriate for people who do not want assistance or do not believe they have issues that need to be addressed. Further, some clients find attending court inherently stressful and this stress overshadows any benefit the List may offer. This is particularly the case where the offending is minor and the client is not facing a term of imprisonment or other onerous sentencing disposition. In such cases clients have either not participated and been exited from ARC, or chosen to have their matter moved to mainstream court.

At court – client experiences

In the ARC List, hearings take place with all parties, including the Magistrate and clinical staff sitting around an oval table. Clients sit beside their lawyer, along with their support worker or family member/s. Hearings begin with the Magistrate introducing him or herself and the other court staff to the client and explaining their respective roles. In discussing the client’s situation, goals and progress, all parties are encouraged to contribute and express their opinions. Clients traditionally associate coming to court with punishment and, often, jail. Speaking openly about themselves can be difficult. As a result, it can take a number of appearances in court before clients feel comfortable with the process. The topics that are discussed are many and varied. They range from employment and family relationships to more unusual topics such as football teams and pets. Because the conversations are led by the client, they generally focus on things that are most important to the individual.

The operation of the ARC List is in marked contrast to clients’ previous experiences of court, where they are often the subject of discussion, but rarely a participant. Through the ARC List process, clients go from having solutions imposed on them by the court to being the ones driving the discussion. Having this level of trust and responsibility bestowed upon them can be empowering for clients and a great motivator to succeed.

The impact the List is having on the lives of clients becomes clear when cases come back before the Magistrate for review. When a client’s positive progress is discussed they often express how proud they are of their achievements. Similarly, if things have not been going well, clients speak about not wanting to let the Magistrate down and hoping to get back on track. Clients have even taken to bringing photographs, artwork and certificates to court to show the Magistrate what they are achieving.

Lawyers’ experiences in court

In mainstream criminal matters, lawyers act as a filter for clients. They try to ensure that their client is presented in the most favourable light. Because clients in the ARC List speak directly to the Magistrate, issues that would normally be considered taboo for defence practitioners, such as the recent use of illicit substances, are commonly discussed. The unpredictability of this scenario can be uncomfortable for lawyers. The process necessitates a change of approach from the traditional adversarial role of advocate to a more open and collaborate approach.

Benefits of the List for lawyers

When preparing matters for court, criminal lawyers spend a considerable amount of time linking their clients in with support services. Successful engagement with such services can be taken into account by the court when determining...
For some, the List has provided a way to break the cycle of offending, which has led to dramatic benefits for them and the community. However, even those who have not successfully completed the program have made some positive changes. All parties involved have gained a better understanding of the roles and functions of other participants. This has led to a more collaborative approach to the passage of matters through court.

**Benefits of the List for support workers**
The List has seen an increased participation of support workers in the court process. In some instances, services have been concerned that their client’s participation in the List may result in them being over-serviced. However, court staff consulting with services prior to and during the court process has ensured that roles are clearly delineated and services are not duplicated. Further, having workers being involved in the court process has led to a greater mutual understanding between the parties. Lawyers come to understand the treatment goals and case workers, the forensic issues at play. This enables parties to work together to achieve better outcomes for clients.

**Outcomes**
For clients who successfully complete an episode in the ARC List, the benefits are clear. Achievements can range from maintaining abstinence from drugs and alcohol to reconnecting with family members, or finding stable accommodation. Clients who have achieved such goals speak of being given a ‘second chance’ and are extremely grateful to the court for having been given the opportunity to participate. To see the change in these clients is incredibly rewarding. For some clients, however, the achievements may be more modest. There have been cases where clients have relapsed into drug use and offending behaviour and been exited from the List. However, even in these cases, the List has usually made some positive impact. Clients may have made the first attempt to stop using drugs or reduced the frequency of their contact with police and emergency services. In such cases, it is important to recognise that even small achievements are significant and may be part of an incremental process of change. Importantly, those clients who do not successfully complete an episode in the ARC List are not punished for this. Magistrates are prohibited from taking the client’s failure to complete the ARC program when determining a sentence.

**Conclusion**
Practicing as a lawyer in the Assessment and Referral Court (ARC) List is a challenging and rewarding experience. The List works best when clients are motivated to address their issues and court staff, support workers and lawyers work together with the client to get the best outcome. There have been varying degrees of success for the clients who have participated to date. For some, the List has provided a way to break the cycle of offending, which has led to dramatic benefits for them and the community. However, even those who have not successfully completed the program have made some positive changes. All parties involved have gained a better understanding of the roles and functions of other participants. This has led to a more collaborative approach to the passage of matters through court. It is certain that for the remaining two years of the pilot, new experiences and challenges will continue to arise.
Penal solutions to social problems

Indiana Bridges, Lawyer and Coordinator of the Inside Access project, Mental Health Legal Centre Inc.

As participants in the criminal justice system who are living with mental illness, often they have experienced alienation from the legal system. This may be the result of a variety of factors, including an inability to understand legal jargon, not having court processes properly explained, being mentally unwell, not having a legal advocate who has some background knowledge of mental illness, or a Magistrate who does not following the precepts of therapeutic jurisprudence.

Inside Access

Inside Access is an innovative prisoner advocacy/legal service, which was first piloted by the Mental Health Legal Centre (MHLC) in 2008. It is a non-government funded project, which delivers therapeutic justice to incarcerated persons in Victorian prisons, with the assistance of a talented team of pro-bono lawyers from DLA Phillips Fox and Blake Dawson, as well as a significant contribution from a dedicated team of volunteers from many of Victoria’s law schools.

The project was developed in response to the alarming over-representation of people with mental illness in the criminal justice system and the inherent difficulties of accessing justice whilst incarcerated. The services currently provided by the project include:
• legal advice and associated advocacy, support and referral services for incarcerated persons when dealing with a legal need
• legal education for incarcerated persons about their legal rights and promotion around understanding the legal and mental health systems
• community education, training and resources to groups, professionals, workers and individuals to increase awareness of mental health legal issues and associated matters
• evaluating and monitoring of existing laws, legal and mental health service standards, policies and procedures, working towards reform in areas of relevance to those living with mental illness in the criminal justice system, and advocating towards systemic change where necessary
• delivery of a legal clinic at the Dame Phyllis Frost Centre, Melbourne Assessment Prison and Thomas Embling Hospital. The aims of the project are to deliver a specialised legal service for clients to address their immediate legal needs. When a client presents with a matter that is beyond our resources or expertise, we will actively seek to refer that client to another legal practitioner or other service provider, which is better equipped and willing to assist.

Our ongoing networking and collaboration with other service providers, has ensured that the Inside Access project increases understanding of the legal profession, government and community sector in the issues affecting people with mental illness in prison.

Over the past 15 months, the project has written a number of law reform submissions relating to mental health and criminal justice. This included submissions to the Victorian government on the Diversion and support of offenders with a mental illness – Guidelines for best practice consultation draft in February 2010, and the discussion paper Transforming VCAT in June 2010, (both in collaboration with the Mental Health Legal Centre), and presenting oral and written submissions to the Drug and Crime Prevention Committee parliamentary inquiry into the Impact of Drug-Related Offending on Female Prisoner Numbers in June 2010.

The impact of Inside Access on advocacy and legal services
The impact of the Inside Access legal clinics has been measurable through the overwhelmingly positive response of clients, stakeholders, and through our partners. We provide a specialised service, a portal for clients to access information and referral pathways that may otherwise be difficult for an incarcerated person to initiate or access. In addition, our partners and pro-bono lawyers are provided with an opportunity to gain experience and greater exposure to the social aspect of the law by directly assisting clients who are living with a mental illness. Law students (who may have degrees in psychology, social welfare or criminal legal studies), are able to work directly with clients, under the supervision of lawyers, to develop their practical legal skills.

Examples of our work in assisting people include:
• fostering human rights – access to medical records and physician treatment plans for the purpose of representing clients at Forensic Leave Panel hearings
• facilitating interpreter services with lawyers and clients, where there is little or no spoken English
• providing advocacy – legal representation at VCAT hearings and Magistrate Court hearings
• communicating with clients’ trial lawyers to assist clients’ information pathways
• assisting clients to seek a merits review on appeal of their sentence
• liaising with Department of Housing representatives to assist with tenancy issues
• liaising with family members in relation to cultural needs.

We work together with courts and other legal service providers to ensure our clients have the best support necessary. For example, clients wishing to challenge an Administration Order are referred to a financial counsellor from Good Shepherd, who will attend the prison to assess the client. On one recent occasion, a client wishing to challenge her Administration Order sought our legal assistance. She had been diagnosed with an acquired brain injury and was soon to be leaving prison. Inside Access facilitated a one-to-one session with a financial counsellor from Good Shepherd, who attended prison and provided a letter in support to the Tribunal. The VCAT Member made reference to the letter and was, in turn, satisfied with the letter of opinion provided by the financial counsellor, which stated that the client was sufficiently well to manage her own funds. In that case, the Administration Order was revoked.
Frequently, Inside Access works with clients to ensure their outstanding debts do not escalate whilst they are incarcerated and unable to pay. One client writes:

*I write just a short letter offering your firm my deepest heartfelt appreciation in your supporting both my partner and myself in our request to suspend our loan repayments.*

Another client writes:

*Inside Access provide a vital, invaluable support and advocacy resource for female prisoners, and we feel it is important this organisation receive continued funding.*

**Profiles of prison inmates**

There is a particular emphasis on lived experiences of clients of the service. The recent past of many who go to jail, shows that they were likely to have been alienated from society in some way, either through social exclusion, lower levels of education, unstable accommodation and homelessness, substance abuse, domestic violence leading to marital and family breakdown, unemployment, suffering through undiagnosed mental illness, gambling due to stress around debt issues, stealing goods and cars, driving under the influence of alcohol, defaulting on fines, violating a parole order (or revoking their own parole in fear that they may re-offend), abusing family members, (which may be attributed to failure in taking medication) and/or defying control orders.

As participants in the criminal justice system who are living with mental illness, often they have experienced alienation from the legal system. This may be the result of a variety of factors, including an inability to understand legal jargon, not having court processes properly explained, being mentally unwell, not having a legal advocate who has some background knowledge of mental illness, or a Magistrate who does not follow the precepts of therapeutic jurisprudence. For others who live with mental illness, they may be reluctant to pathologise their behaviour and would prefer taking responsibility for their actions where it may feel more appropriate to do so. Some clients feel stigmatised and are in fear of being discriminated against if it is revealed that they have a mental illness. However, it is evident that punitive sanctions alone do not lead to a safer community – the available research does not support the effectiveness of imprisonment as a specific deterrent to re-offending and, in fact, suggests that it may indeed increase recidivism.

Inside Access aims to be one of many preventative mechanisms that help divert people with mental illness out of the criminal justice system. By focusing on prevention through access to legal rights and education, Inside Access can empower people to enforce their legal rights and to access appropriate supports.

However, in order to provide an integrated and preventative response, diversion out of the criminal justice system for people with mental illness is vital. For example, mental health professionals can play a significant role in diffusing a situation before it develops into a crisis. Similarly, police have the discretion not to charge a person suspected of committing an offence, and divert them away from the criminal justice system, into appropriate care and treatment.

Diversion and support programs can facilitate a person’s human rights, including rights under the United Nations’ Convention on the Rights of Persons with Disabilities, which includes rights to: equal recognition before the law (article 12), access to justice (article 13), independent living and support (article 19), health care (article 25) and rehabilitation (article 26). These rights can be impaired if mental illness goes undetected or is not taken into account by the criminal justice system.

Legal service providers need to deliver strong and effective advocacy and ensure that decision makers understand the impact of a person’s mental illness as well as other circumstances. This is one of the fundamental roles of the Inside Access project.

**References**

1. See Mental Health Legal Centre Report (2010) Experiences of the Criminal Justice System – the perspectives of people living with mental illness
2. The National Survey of Mental Health and Wellbeing 2007 found that among people who have previously been incarcerated, 41 per cent reported a mental illness in the past 12 months, double the rate of people without a history of incarceration, Australian Bureau of Statistics (ABS) (2008c), National Survey of Mental Health and Wellbeing 2007: Summary of results, ABS, Canberra
3. Research has shown that offenders have higher rates of mental illness than the general community. Continued attention is required to be focused on understanding the reasons for the disproportionate prevalence of mentally ill people in the criminal justice system
6. See Mental Health Legal Centre Report, n 4
Neighbourhood justice

Caroline Ottinger, Communications Manager, Neighbourhood Justice Centre (NJC)

During his pre-sentence involvement with the Neighbourhood Justice Centre (NJC), DS’s progress and compliance with treatment goals was subject to judicial monitoring via a series of court return dates. During the course of these court appearances, his maintenance of an offence-free lifestyle and his attendance at regular case management and treatment appointments were discussed with the presiding Magistrate. DS was also successful in securing construction work employment during this period.

The following case study describes the involvement of a recent client (known as DS) with the Client Services Team and Magistrates’ Court of the NJC in Collingwood. It is intended to demonstrate the impact of comprehensive, multi-disciplinary treatment and support services on the client’s ability to rehabilitate, including to cease offending, successfully complete his court order, gain employment and address personal and treatment goals.

Background
DS was a 32-year-old single, unemployed man who was awaiting the hearing of a series of offences (property and substance-related) listed at the NJC in Collingwood. DS had a long-standing history of involvement with the criminal justice system, having previously been subject to a series of community based orders (CBOs), repeated periods of imprisonment and was, at the time of referral, subject to a Suspended Sentence.

DS described a long history of behavioural difficulties, and depicted his childhood and adolescence in predominantly negative terms. He described encountering difficulty in maintaining appropriate patterns and standards of behaviour during childhood and adolescence. DS left school at age 14 due to increased difficulty concentrating and failure to keep up with his peer’s educational achievements.

DS described using substances during his early childhood and reported commencement of illicit substance use during his adolescence. DS identified previous engagement in offending behaviours, both to support his substance use and in response to childhood indoctrination into offending behaviours within his family.
Treatment and support services at the NJC
Upon attendance at the NJC Magistrates’ Court, and entering of a plea of Guilty, DS was referred to the generalist counsellor provided by the North Yarra Community Health Centre for pre-sentence assessment. His court matters were subsequently adjourned for a period of time to allow for this assessment to take place. At the initial assessment, DS identified a series of personal and treatment goals involving maintenance of a drug-free lifestyle, securing gainful employment, and intervention in relation to unmet mental health needs (depression and anxiety).

Following the initial assessment, DS was referred to a number of services based at the NJC and was engaged in case management provided by the NJC’s Client Services Team. DS was referred to the employment pathways worker (provided by the Brotherhood of St Laurence) for vocational assessment, and to the mental health clinician (provided by St Vincent’s Mental Health Service) for further assessment and identification of unmet mental health needs. He was also referred for an Alcohol and Other Drug assessment (provided by Odyssey House Victoria).

Vocational assessment identified that DS had a history of employment including successful completion of a trade Apprenticeship and was highly motivated toward returning to gainful employment. The employment pathways worker provided DS with information regarding relevant training courses in his identified area of employment interest and provided further appointments to support him in re-entering the workforce.

Alcohol and Other Drug assessment identified that DS’s current treatment program was successfully assisting him to maintain a substance-free lifestyle, and that the counselling and support services he had engaged with at the NJC were supporting him to comply with treatment and attainment of treatment goals. DS was not subsequently referred for further treatment of his Alcohol and Other Drug needs. However, the Alcohol and Other Drug assessment role was accessed during DS’s involvement with the NJC, to provide secondary consultation and advice in relation to DS’s case management and treatment.

DS was referred for a mental health assessment in response to his self-reported history of depression and anxiety. He described a history of involvement with public mental health services having previously been subject to involuntary inpatient psychiatric admission as a consequence of periods of increased rumination on suicidal thoughts and engagement in suicide attempts and self-harming behaviours. DS also described a family history of serious mental illness. During the course of assessment, DS related a history of grossly disordered behaviour, impaired cognitive functioning (most pronounced in the area of his executive functioning) and experience of difficulty in sustaining his concentration and responding to competing/changing personal demands/needs. DS also described a history of experience of depressive symptoms, and whilst these were identified as having a significant impact upon his personal functioning, he was ambivalent about engaging in treatment. At the time of assessment, DS reported having previously been prescribed antidepressant treatment, which he failed to take as prescribed. He was ambivalent about further involvement in treatment.

Due to DS’s complicated personal and mental health history, he was provided with assessment over a series of sessions during which he agreed to a referral to the Acquired Brain Injury Assessment Unit for cognitive assessment and a private psychiatrist for further assessment of his mental health needs and treatment recommendations.
Longitudinal mental health assessment identified DS as demonstrating residual symptoms of a childhood pervasive developmental disorder (Attention Deficit Hyperactivity Disorder (ADHD)). He commenced a course of appropriate treatment. The mental health clinician helped DS develop coping strategies to compensate for and address the impact of these symptoms on his daily functioning and basic problem solving.

**Pre-sentence judicial monitoring**
During his pre-sentence involvement with the NJC, DS’s progress and compliance with treatment goals was subject to judicial monitoring via a series of court return dates. During the course of these court appearances, his maintenance of an offence-free lifestyle and his attendance at regular case management and treatment appointments were discussed with the presiding Magistrate. DS was also successful in securing construction work employment during this period.

**Sentencing**
Upon finalisation of DS’s matters he was deemed to have demonstrated Exceptional Circumstances as evidenced by identification of a pre-existing diagnosis of ADHD, demonstration of ongoing symptoms of this disorder, and productive engagement in treatment and case management (both of which were significant departures from his previous history of very poor engagement with treatment/services). DS was then sentenced to a two-year Community Based Order and contemporary Suspended Sentence.

**Community Correctional Services and the Court Review process**
After sentencing, case management of DS was transferred to Community Correctional Services (CCS) based at the NJC. The Client Services Team gave all relevant treatment and support information to CCS.

During the course of DS’s CBO, he was subject to a regular calendar of court reviews, as is standard practice at the NJC, and was proactively engaged with case management provided by CCS, with specialist input provided by the Client Services Team as required. DS also maintained regular contact with the support services (both internal and external to the NJC) engaged during his pre-sentence period with the NJC.

In addition to monitoring his compliance with treatment and other program conditions attached to the CBO, his CCS case manager assisted DS to identify how his mental health, substance abuse and upbringing directly contributed to his offending behaviour, and to develop strong relapse prevention strategies to reduce his risk of future offending.

The CBO Court Review process facilitated discussion between DS, the Magistrate and relevant support agencies of his progress toward the completion of this order and achievement of treatment goals. This process of reviews found that DS had successfully completed all relevant conditions of the order and had been successful in addressing the identified underpinning factors associated with his previous offending. In consideration of this, and the lengthy period of time that DS had been subject to this CBO, the Magistrate suggested that he make an application for confirmation of the order prior to its termination. DS made such an application that resulted in his order being confirmed and subsequently terminated early. DS remained subject to a Suspended Sentence, which could provide an expedient response to any further offending.

At the time of completion of his Suspended Sentence, DS had continued to maintain a drug- and offence-free lifestyle and was productively engaged in the gainful employment that he had secured prior to sentencing. He was also pursuing accommodation in the private rental market, having resided with his immediate family members during the course of his involvement with the NJC.
Smart Justice, a coalition of community organisations, is led by the Federation of Community Legal Centres (Victoria) Inc., which is the peak body for Victoria’s 50 community legal centres including the Mental Health Legal Centre. The aim of Smart Justice is to enhance the safety of all Victorians by promoting understanding of criminal justice policies that are effective, evidence-based and human rights compliant. The project is built on a joint commitment to a greater focus on crime prevention and cost-effective crime prevention strategies.

We advocate for greater resources to address the causes of crime by tackling underlying factors that contribute to offending, through increased investment in child protection, family support, housing, employment, education, mental health and drug and alcohol programs.

The organisations involved in Smart Justice have a vast array of experience working in the criminal justice system. We know from our work with clients that we need to substantially increase investment in early intervention community mental health care. This is because there is a serious over-representation of people with mental health problems in prison. For example, 85 per cent of women in prison in Victoria have a mental disorder. Prison is far more expensive than community mental health care; it fails to rehabilitate people and can actually exacerbate mental illness.

An encouraging new initiative to reduce the number of people who end up in prison is the Assessment and Referral Court pilot program at the Melbourne Magistrates’ Court. The program provides specialist support for people with a mental illness and/or a cognitive impairment including clinical assessment, welfare and mental health referral and drug and alcohol treatment. While the program has not yet been evaluated and is only available to people who plead guilty, it aims to reduce the number of people with mental impairment in prison.

Another impact of our under-resourced community mental health care system is that timely support for a person with a mental health problem is not always available. Unfortunately, an untreated problem can escalate into a mental health crisis to which armed police are called to respond, sometimes with fatal consequences. From our work and research we know that people with mental illness are overrepresented in fatal police shootings in Victoria. Part of the solution is better police training in identifying and responding to people experiencing mental health crises, including better communication and negotiation skills. As promised by the new coalition State Government, we want to see Victoria Police working alongside mental health experts to develop specialised mental illness training for all police officers as well as the 940 new protective service officers.

Our new State Government has made some encouraging policy statements in relation to early intervention programs and greater resources for the mental health system. Smart Justice will be monitoring those policies as they are developed, and will then be evaluating their effectiveness when they are implemented.

FIND OUT MORE: The Smart Justice project now involves 21 leading community and legal agencies and they are always keen to get more partners involved. You can find out more information about the project at: www.smartjustice.org.au.

Michelle McDonnell, Smart Justice Policy Officer, Federation of Community Legal Centres, (Victoria) Inc.
The Taskforce

The Inter-Church Criminal Justice Taskforce is part of the Victorian Council of Churches (VCC). It supports a restorative, rehabilitative and community-based justice system to reduce offending and re-offending, with imprisonment as the last resort.

Observations about mental health and the justice system

An area of interest to the Taskforce is mental health. The increase of people with mental health problems in Victorian prisons reflects an increasing prevalence of mental illness, a failure of health services to intervene before the illness causes social harm, and inadequate prevention or early intervention within the justice sector. The following damning observations are drawn from the report of the previous Victorian Government, Because mental health matters: Victorian mental health reform strategy 2009 – 2019.

Victorian prisons held approximately 1150 people with a diagnosed mental illness (28 per cent of prisoners). Of these, 500 had psychosis and 700 had depressive conditions. The prevalence of psychiatric illnesses is disturbingly higher in the prison population (three to five times more common among prisoners) compared to sample studies of the general community.

The ‘deinstitutionalisation’ of mental health facilities in Victoria has possibly resulted in an increase in the number of people in prison identified as suffering from a mental illness. There is uncertainty as to whether increased prevalence, or increasing reporting, is the main cause of this purported swell in cases. Despite this, there remains a desperate need for effective health services for prisoners and ex-prisoners. Current treatment services are very limited and often ineffectual. Government and community support is required to stem recidivism of mentally ill offenders.

Post-release support programs addressing a prisoner’s holistic needs, including their mental health needs, have been found to be highly effective in reducing recidivism rates (up to 70 per cent reduction). When it is considered that prison beds cost the public more than $100,000 each year, it makes sense to allocate funds for care rather than punishment.

The Taskforce welcomes support and involvement from the religious and non-religious alike.

References


FIND OUT MORE. You can contact the author at D.Fitzgerald@css.org.au. The following lists further reading on the topic of this article:


Church leaders call for less focus on locking up criminals http://www.heraldsun.com.au/news/victoria/church-leaders-call-for-less-focus-on-locking-up-criminals/story-e6frf7kh-1225903176736

Mental health law reform – the Mental Health Bill Exposure Draft and beyond...

Catherine Leslie, Lawyer and Policy Officer, Mental Health Legal Centre Inc.

Consumers at the forum were sceptical that changes to the treatment planning, which would require the treating team to adopt a ‘collaborative’ approach (with the person, their nominated person and a carer or family member with the consumer’s consent), would be as constructive and beneficial as they could be. So much otherwise depends upon the relationship a person has with their treating team.

Of all the tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive... [for] those who torment us for our own good will torment us without end for they do so with the approval of their own conscience.

So remarked C S Lewis, and so quoted Mary O’Hagan, psychiatric survivor, internationally renowned consumer educator and former New Zealand Mental Health Commissioner, in her presentation entitled ‘Compulsory treatment – risky business’, during her visit to Melbourne in September 2010.

The quotation serves as a poignant reminder of how insidious paternalism and so-called beneficence can be. Although not everyone will necessarily identify with the language of ‘oppressor’ and ‘victim’, the power imbalance it invokes is all too keenly felt by people living with mental illness who find themselves subjected to forced psychiatric treatment and detention under the Mental Health Act 1986. The Victorian Government’s Review of the Mental Health Act 1986—its first whole scale review in nearly 20 years—has brought pause to challenge this dynamic and the culture of service provision and provide alternatives in law, which further the rights of, and empower people with, mental illness in Victoria.

After the waves of hope, scepticism and criticism in the government’s community consultation process, a draft of what a new Act might look like (called the Mental Health Bill Exposure Draft 2010) was released for public comment in October 2010. At 400-odd pages, just reading through the Draft Bill is, in itself, an achievement. It is another thing again to navigate through the detail and the density of the proposed Draft Laws to try to determine its impact on the people ‘about’ whom and ‘for’ whom it is written: mental health consumers.
Prompted by the complexity and, in some cases, ambiguity of the Draft Laws and the desire to find out directly how mental health consumers felt about the proposed new laws, the Mental Health Legal Centre (MHLC), in February 2011, held a consumer discussion forum on key topics. As a statewide specialist community legal centre providing legal services to people with or labelled as having a mental illness, the MHLC undertakes education, policy and law reform activities, which aim to further the rights of mental health consumers. It was fitting therefore that the discussions, views and experiences shared by consumers at the forum, entitled ‘What mental health consumers want from mental health laws’, fed directly into the MHLC’s submission to the Draft Bill.

Many people will already have perused the Explanatory Guide, which the government produced to accompany the Draft Bill. Within it states that the proposed new laws reflect a ‘rights-based approach’ to laws governing the provision of public mental health services, which, as we know, have traditionally focused on regulation of involuntary treatment and detention, based on defined criteria. Consumer participants at the forum however, remained sceptical about whether the culture of mental health service provision, so focussed on coercive treatment, would shift to an ‘empowering and participatory’ framework where voluntary treatment really is the focus of care.

As one person remarked:

Is there anything in this Act that’s going to change what happens now? ‘Cos you can... get attended to at a clinic if you are made “involuntary”. Everyone talks about voluntary patients but [try] showing up saying, “I’m in distress” and you won’t get in if they don’t see you’re serious enough... [as a voluntary patient] you’ll be the first one kicked out.

Such attendant problems in people accessing services they desire, consistently with their expressed needs, reinforces the findings of the government-commissioned report by the Boston Consulting Group in 2006. Even when people are in acute distress or mental health crises, their needs are not prioritised and rather, it is other concerns that determine the actions of services, including staff attitudes and pressures around lack of training and resources.

Consumers continue to clamour to have their voices heard and their concerns and views seriously taken into account and acted upon by clinical services. As a party to the Convention on the Rights of Persons with Disabilities (CRPD), Australia has an obligation under Article 4 to ensure and promote the full realisation of all human rights and fundamental freedoms without discrimination of any kind on the basis of disability, including mental illness. This includes adopting all appropriate legislative and administrative measures for implementation of these rights and ensuring public authorities act consistently with human rights. The Preamble rightly recognises that:

Persons with disabilities continue to face barriers in their participation as equal members of society and violations of their human rights in all parts of the world.

**Supported decision-making**

Reform of the law should start from the premise that all people, regardless of diagnosis of disability or otherwise, have equal rights to exercise control over, and participate in, their own decision making, and the right to have access to appropriate supports to facilitate this. If there is to be a separate mental health law at all—a question which is beyond any doubt in the Government’s Review—it must facilitate the reality of supported decision making for people consistent with Article 12 of the CRPD. That is, the law must provide mechanisms for a person to make decisions for themselves, for example when they are well, in advance of a crisis, and to be provided with support in doing so.

In this respect, consumers at the forum were resoundingly in favour of the introduction in the Draft Bill of measures to enable themselves to appoint a legally-recognised support person (‘nominated person’) and to draft their wishes and preferences in a legally-recognised document (‘advance directive’). Nevertheless, what the proposed laws provide is not necessarily commensurate with what consumers want such measures to achieve.

People at the consumer forum were generally in support of the nominated person scheme, which, to some, was the only benefit they could see in the compulsory treatment and treatment planning provisions in the Draft Bill. It was consistently felt, however, that the scheme, as envisaged under the proposed laws, was too restrictive. Why should a person be limited to nominating only one support person to be informed of, and consulted about, every aspect of care and treatment? Why shouldn’t the person determine what and how much information
Reform of the law should start from the premise that all people, regardless of diagnosis of disability or otherwise, have equal rights to exercise control over, and participate in, their own decision making, and the right to have access to appropriate supports to facilitate this. If there is to be a separate mental health law at all—a question which is beyond any doubt in the Government’s Review—it must facilitate the reality of supported decision making for people consistent with Article 12 of the Convention on the Rights of Persons with Disabilities.

What do we want the law to do? Advance directives that override everything else, i.e. if I say I don’t want ECT or a certain medication in my advance directive when I’m capable, that should be respected even if I’m made involuntary. It shouldn’t be able to be overridden.

**Safeguards and external review of compulsory treatment orders**

Where a person is subjected to involuntary treatment, robust legislative safeguards including independent reviews and appeal mechanisms are critical to ensure that a person’s rights are not disproportionately infringed, consistent with the *Victorian Charter of Human Rights*. Key rights in this respect, are the rights to be free from medical treatment without consent, to be free from cruel, inhuman and degrading treatment, to privacy and bodily integrity and to humane treatment when deprived of liberty.

In the Draft Bill, despite the move to a staged system of involuntary treatment orders (now named Compulsory Treatment Orders, or CTOs), some tightening of the ‘five criteria’ for compulsory treatment, and a shift in the process to one of prior Mental Health Tribunal (Tribunal) authorisation, before the making of extended compulsory orders, many people at the consumer forum clearly felt there was unlikely to
be any really significant change in the compulsory treatment regime as a whole. Some proposed changes might even be described as taking one step forward, only to then take two steps backward. For example, while the Draft Bill’s limiting of an ‘initial’ CTO to three-months was seen as an improvement on the current 12-month (maximum) length, the fact that beyond that, an order would be longer — up to 18 months — was roundly criticised. It is well known that Victoria has the highest use of forced community outpatient treatment of anywhere else in the world where, as Psychiatrist Dr Gunvent Patel describes, mental health clinicians have ‘actively engaged in their use with an almost religious, unquestioning zeal’.

Consumers at the forum were sceptical that changes to the treatment planning, which would require the treating team to adopt a ‘collaborative’ approach (with the person, their nominated person and a carer or family member with the consumer’s consent), would be as constructive and beneficial as they could be. So much otherwise depends upon the relationship a person has with their treating team. As one consumer explained:

[The treatment plan] should be looked at, at least weekly and [the person] should have explanations given to them as to what decisions are being proposed and why they’re being proposed so they are then in a position to give informed consent. It’s very hard to give informed consent if you do not know and have not had… explained to you the reasons… why the decisions are being made.

Overall, the external review and oversight of compulsory orders by the Tribunal—to the extent that this is seen as a sufficiently independent body—appear to be weakened in the Draft Bill. The introduction of a new position of review officers to conduct an initial ‘procedural check’ on orders and provide rights advice was problematic, not least of all because of their lack of independence of the Department and decision-making power. It was clear that a review officer could not be said to be acting on behalf of and for the benefit of the person, rather they appeared to be a check and balance for clinical services. One consumer said at the forum:

…You wouldn’t need a review officer if everyone’s doing their job! Why’s the person there in the first place?

Consumers are understandably gravely concerned that a person may be subjected to involuntary treatment in the community for up to three or four months without a Tribunal hearing to review the validity of the order, and for inpatients, up to around seven weeks, which represents no meaningful improvement on the current Act’s eight-week initial review – a statutory review period, which was roundly criticised during the Review’s community consultation, as far too long and which violates a person’s rights.

One aspect of the Tribunal’s additional powers in the Draft Bill of which consumers were overwhelmingly in favour, is a new system requiring prior Tribunal authorisation of ECT before it can be performed – the first time that Victoria has had such a system.

Conclusion

Mental health consumers, advocates, lawyers and the community at large keenly await the outcome of the reform of mental health laws through both the government’s Review, as well as the Victorian Law Reform Commission’s review of guardianship laws. The Commission is also considering similar issues such as supported decision making and the interaction between guardianship and mental health laws and is due to report later in the year.

Genuine meaningful reform to promote the rights of consumers consistently with the CRPD is desperately needed. As Tina Minkowitz, psychiatric survivor and lawyer, commented in an earlier issue of this very journal:

If reform cannot deliver any real improvement, it does not serve the purpose of social justice and instead functions as a junk substitute that deflects the energy of a movement and limits people’s imaginations.

VICSERV can provide this article with its full list of references. To request a copy, please contact Kristie Pate on 03 9519 7000 or k.pate@vicserv.org.au
The power of peers

Maria Katsonis, Victorian Public Servant in the Department of Premier and Cabinet, and Co-Convenor of Open Minds

Critical to the success of Open Minds, is the fact that the program and its activities have been managed and run by people who have first-hand experience with mental health issues. This peer base has given the program a level of credibility and authenticity in the eyes of Open Mind’s intended target groups.

‘From little things, big things grow’, sang Paul Kelly. These lyrics equally describe the first year of Open Minds, a volunteer peer-directed group for Victorian Public Service (VPS) employees who have a mental illness, or are caring for someone with mental illness. Established in 2010, Open Minds provides a range of programs for mental health consumers, carers and people with an interest in mental health issues. It is the first whole-of-VPS program to specifically target mental health issues in the workplace.

Since its inception, Open Minds has been shaped and driven by its two co-convenors and their own lived experience of mental illness and caring. In establishing Open Minds, the co-convenors drew heavily on the concepts of peer support. Peer support is social and emotional support (that is mutually offered or provided by people with a mental health condition, or who care for someone with a mental health condition), to others sharing a similar condition or situation. It has been described as ‘a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful’ (Mead, Hilton, and Curtis 2001).

The literature on peer support highlights a range of benefits.

• **Acceptance, empathy, and respect**
  Sally Clay (2005) describes this empathy for people with a mental illness as follows: Since we have been crazy ourselves, we feel compassion for the confusion of others rather than fear of their madness, and we strive to offer unconditional respect to those who are ‘in the same boat’ as we are.

• **Sharing what works, strategies for recovery and fostering hope**
  By telling their own stories of recovery, peers can provide encouragement and act as a role model to show that recovery is possible (Clay, 2005).

• **Empowerment and affirmation**
  Peer support promotes a culture of health and ability rather than one of illness and disability (Mead et al, 2001).

Since it was established in February 2010, Open Minds has undertaken an ambitious program of activities. This has included seminars, forums, outdoor exercise events, information provision and commissioning beyondblue to deliver a workshop designed specifically for the Victorian Public...
Service to increase managers’ competencies and capabilities in managing staff with mental health issues. While Open Minds receives a modest amount of program funding, all programs are delivered within a volunteer organisational base.

Table 1 shows the level of program activity delivered in 2010.

<table>
<thead>
<tr>
<th>Level of program activity delivered in 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of seminars</td>
</tr>
<tr>
<td>Open Minds seminars attendees</td>
</tr>
<tr>
<td>Number of managers training workshops</td>
</tr>
<tr>
<td>Managers training participants</td>
</tr>
<tr>
<td>Number of Mental Health First Aid courses</td>
</tr>
<tr>
<td>Mental health first aid attendees</td>
</tr>
<tr>
<td>Mental Health Week Festival events</td>
</tr>
<tr>
<td>Exercise your mood walk/run events</td>
</tr>
<tr>
<td>Exercise your mood walk/run participants</td>
</tr>
<tr>
<td>Subscribers to the Open Minds e-Newsletter</td>
</tr>
<tr>
<td>Open Minds Healthy Minds bookmarks distributed</td>
</tr>
</tbody>
</table>

Table 1: Quantitative overview of Open Minds

The rapid growth of Open Minds has been in response to the demand from consumers, carers and managers who are looking to do more than simply send staff to employee assistance programs. In order to better understand the demand drivers and the impact of Open Minds programs, Open Minds commissioned The Nous Group to conduct an evaluation. The evaluation was partly funded by beyondblue who were interested in exploring the workplace effectiveness and advantages of a peer-directed model in engaging the workplace about mental health. The evaluation found that Open Minds had a positive impact on the attitudes, behaviour and wellbeing of many VPS employees, with an ambitious program of activities that has targeted three fairly distinct groups of employees:

1. consumers of mental health services
2. people who care for a person with mental health issues
3. managers and colleagues of people affected by mental health issues.

Program participants cited greater understanding and awareness as the most common impacts. Figure 1 (below) graphically represents the most common of the 448 responses to the online survey question ‘what have you personally gained from participating in Open Minds?’

Figure 1: Textual analysis of survey responses

Open Minds has been highly successful at raising awareness of mental health issues among the VPS employees who have actively chosen to participate in the program. The majority of managers and colleagues who have been involved with the program identified changes in their own knowledge, attitudes and behaviour since attending an Open Minds activity.
There is considerable scope for Open Minds to positively impact significantly more people in the Victorian Public Service. The challenge for Open Minds in moving forward is to extend the reach of its program activities, while preserving the elements of the program – particularly peer-directed support – that have made it successful.

<table>
<thead>
<tr>
<th>Change in behaviour</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better understanding of what it is like to experience a mental illness or care for someone who does</td>
<td>90%</td>
</tr>
<tr>
<td>Greater understanding of how mental illness may affect that person in the workplace</td>
<td>90%</td>
</tr>
<tr>
<td>Felt more comfortable talking with their colleagues about mental health issues</td>
<td>82%</td>
</tr>
<tr>
<td>Talked with colleagues about how their workplace can better support colleagues with a mental illness, or colleagues caring for someone with a mental illness</td>
<td>59%</td>
</tr>
</tbody>
</table>

Table 2: Affirmative responses to the question ‘Since you attended an Open Minds activity, have you:’ (n=164)

The results in Table 2 indicate that the majority of participants have actively changed their behaviour by engaging in activities such as conversing with colleagues affected by mental health issues.

Additionally, Open Minds has enabled a substantial number of program participants to talk more confidently and openly with their colleagues about their mental health issues. Participants also reported feeling less isolated after becoming better connected to their peers and suitable support services. For many VPS employees, Open Minds has provided their first opportunity to talk about mental health in the workplace and seek assistance.

I have never previously received any information or support around mental health issues directly from a government agency; all the information and advice I have received has been through Open Minds.

Open Minds has also provided program participants with the opportunity to meet and connect with other people affected by mental health issues for the first time. Building these new communities has resulted in a considerable number of people feeling less isolated and alone.

I feel less alone because I know that there are others across the VPS who are experiencing similar things to what I have experienced.

Other survey respondents and focus group participants talked about how Open Minds has empowered them to discuss mental health issues in their workplace.
[I have gained] the personal courage to speak more openly about my own experience, a learning from others in Open Minds. [I have gained] more confidence in dealing with my own mental health issues. Discussing it as something that exists in the world helps to objectify it, reducing the sense that it is an intractable problem that is intrinsic to myself.

The Open Minds website has also provided a channel for some VPS employees to publicly speak for the first time about their experience through guest contributions to the blog and the Our Stories page.

Critical to the success of Open Minds is the fact that the program and its activities have been managed and run by people who have first-hand experience with mental health issues. This peer base has given the program a level of credibility and authenticity in the eyes of Open Mind’s intended target groups.

[Open Minds] better understands the issues from a user perspective rather than an often ill-informed expert point of view that further isolates.

Because Open Minds is not affiliated with a particular department, it is seen as community owned. This has created a sense of inclusion and ownership among the participants.

Open Minds is VPS staff driven and this creates a safe, trusted environment for discussions on these topics.

There is considerable scope for Open Minds to positively impact significantly more people in the VPS. The challenge for Open Minds in moving forward is to extend the reach of its program activities, while preserving the elements of the program—particularly peer-directed support—that have made it successful.

References


Figure 2: Screen shot of the Our Stories webpage
RESEARCH
‘I’ve done my time, now what?’

The case for living skills interventions for people with mental health issues at risk of, and beyond, custodial sentences

Muriel Cummins, Program Manager, Community Mental Health, Western Region Health Centre

Louise Farnworth, Associate Professor and Head of Department of Occupational Therapy, Monash University

Protective factors that reduce the risk of re-offending include stable mental health, stable housing, reduced substance use and meaningful occupation. The PDRSS sector will need to step up to leadership roles in the development of partnerships that can facilitate making the ‘wrap around support’ concept a reality.

Introduction
Strong evidence underpins the fact that people with mental health issues are over-represented in the criminal justice system. Research also reports that prolonged incarceration impacts the mental health and living skills necessary for surviving ‘on the outer’. The Psychiatric Disability Rehabilitation and Support Service (PDRSS) sector, and the broader community mental health sector, work with significant numbers of clients who have spent time in prison, and support them as they face the many challenges involved in the transition back to the community. This paper describes one study where participants with mental health issues in prison identified the acquisition of living skills as important to them. The process of supporting people with mental health issues to maintain and develop living skills, so taken as integral to everyday practice in mental health services, can, in reality, be challenging. The findings of this research highlight the case for building workforce capacity to address living skills, and explain why this is an important component of the PDRSS sector’s forensic capacity to work with this complex and vulnerable group.

The literature

Prevalence of mental health issues in prison
International literature indicates that individuals with a mental illness are significantly over-represented within prison populations (Applebaum et al., 2001; Steadman, Osher, Robbins, Case & Samuels, 2009; WHO, 2001). Australian statistics describing the number of people with mental health issues in the criminal justice system are equally alarming. While approximately 20 per cent of the general population in Australia will have had a mental illness within the previous 12 months, those who have been incarcerated have twice this prevalence, at a rate of 41 per cent (Australian Bureau of Statistics [ABS], 2007). When compared to the general population, Australians who have been incarcerated have almost five times the prevalence of substance use disorders, three times the prevalence of affective disorders and twice the prevalence of anxiety disorders (ABS, 2007). Of those in police custody, 30 per cent have histories of psychiatric treatment and 30 per cent of newly remanded offenders have mental health issues (Victorian Department of Health, 2008).
If there are 29,317 individuals in Australian prisons (ABS, 2009), it can be estimated then that 41 per cent, or 12,019 incarcerated individuals are experiencing some form of mental illness every day. Ogloff et al. (2007) claimed that in 2001, of the 15,000 people with major mental illnesses in Australian institutions, one third of those were in prisons. The exact figure is unclear, but it has been well reported that individuals in the criminal justice system have disproportionately higher rates of mental illness, and of major mental illness such as schizophrenia, than the general population (Henderson, 2007; Ogloff, Davis, Rivers, & Ross, 2007; Wilson, 2008). Armstrong (2005) argues that this is likely to be a secondary consequence of an inadequately resourced and overstretched community mental health sector.

As Henderson (2007) explains, while there is no inherent link between mental illness and crime, there is a strong causal link between mental illness and incarceration.

### The impact of the prison environment: mental health and living skills

Spending time in a custodial environment can seriously impact mental health (Hills, 2003; WHO 2001). Deprivation of freedom, by its nature, is not conducive to recovery or positive mental health outcomes (WHO, 2001). Factors that can contribute to a decline in mental health following incarceration include loss of social support from family and friends, lack of control over the immediate environment, lack of choice, isolation, and long hours in lockdown (Hills, 2003). Nurse, Woodcock and Ormsby (2003) investigated the environmental factors that influence mental health within a prison environment, and found that long periods of isolation, combined with limited activity choice, contributed to poor mental health, and in some cases, increased levels of anger, frustration and anxiety. This study also suggested links between the lack of mental stimulation, a decline in mental health, and increased drug abuse within prison. Further studies indicate that an absence of meaningful and purposeful activity and role in a custodial environment increases fluctuating emotional states, stress-related medical problems and disciplinary incidents (Applebaum et al., 2001).

Molineux and Whiteford (1999) suggested that the lack of access to routine activities of daily living, such as doing personal laundry and meal preparation, can lead to longer-term loss of living skills and ability to resume life roles. Engagement in activities that lack challenge, over extended periods, can potentially lead to loss of skills and decreased personal satisfaction and self-esteem (Farnworth, 2000; Whiteford 1995). Wittman and Velde (2001) warned that the structure of security in the prison setting can lead to sensory deprivation. As portrayed so aptly by Goffman (1961), there are a number of reasons for high levels of structure, routine and sameness, mainly to ensure the smooth running of the institution, but in the case of the correctional facility, the underlying assumption is that previous roles, habits and routines are linked to offending behaviour and are therefore ‘maladaptive’. The challenge of coping with a mental health issue in prison can be overwhelming and is often accompanied by a deterioration in social, occupational and living skill function (O’Connell, Farnworth & Hansen, 2010; Muñoz, Farnworth, Hamilton, et al, 2011; Applebaum et al., 2001).

### Transition to the community

Resuming life roles post release can be challenging. There is evidence to suggest that cross sector collaboration, providing ‘wrap around’ support is optimal for a person with mental health issues transitioning back to the community (Department of Health, 2008). There is evidence to suggest that living skill support and training can be keys to a successful transition to community living, which can be compromised as reduced ability to perform living skills on release, potentially leading to increased recidivism (Hills, 2003).
While access to affordable housing is an issue post release (Victorian Department of Health, 2008), maintaining housing can be an even greater obstacle for some (Livingstone & Miller, 2006). Reduced living skill proficiency has been identified as one of the risk factors for tenancy failure (Jones et al, 2004; Western Region Health Centre, Guide to Living Skills Assessment and Intervention, 2008). The inclusion of living skills training results in greater success with obtaining and maintaining housing (Morse et al, 1992). While some living skills, such as cooking, are taught in group programs in community settings, it has been argued that programs that provide one intervention for all participants may fail to meet the individual needs of participants (Mairs & Bradshaw, 2002) and that people with cognitive impairment and people with histories of homelessness and complex needs often require a personalised program to learn living skills (Helfrich & Fogg, 2007). It is suggested that such a program for these groups allow for skill-practice and ongoing coaching (Helfrich & Fogg, 2007). Studies have shown living skills training improve skills in people with serious mental health issues (Brown et al, 2002, Wong et al 1988).

The study
The study was conducted within a prison environment in Victoria, Australia, and aimed to explore the self-perceived daily living skills of participants across a defined set of skills. The Occupational Self Assessment (OSA), (Baron et al., 2006) was utilised as an outcome measure for this study and the full results are available elsewhere (Cummins & Farnworth, 2008). Ethical approval was granted by the Victorian Department of Justice, and all participants were issued a participant information statement and signed a consent prior to interview.

The OSA is widely used as an assessment and outcome measure in the discipline of occupational therapy. As well as measuring the self-perceived skill-level in ‘occupational functioning’ (Gorde et al., 2004), that is, the functional living skills in daily life, it also measures how important, or valuable, each skill is to the person. For each functional living skill, the client firstly assesses how difficult the skill is to perform on a four-point rating scale. Secondly, the client rates each functional living skill in terms of how important the skill is to them. By combining these ratings for difficulty and importance, client-identified priorities for skill development can be established. Qualitative comments in response to the OSA were also captured and recorded on the questionnaire by the researcher.

The OSA questionnaire was completed in interview format with 35 randomly chosen participants with mental health issues, representing approximately 50 per cent of the total population of 69 prisoners with mental health issues incarcerated at this prison at the time of the study. The average age of participants was 32 years, ranging from 18-54 years. All participants were male. Twenty-six were Australia-born, and the other nine were from a range of countries as follows: New Zealand (2), Horn of Africa (3), Cambodia (1), Vietnam (1), Croatia (1), and Greece (1). One participant identified himself as being Aboriginal. The average length of incarceration for the group in this prison environment was three months, ranging from one to eleven months. Twenty of the participants were on remand, and 15 were sentenced. For eleven participants, this was their first period of incarceration. The previous number of incarcerations for the group ranged from one to 12, with an average of three previous periods of incarceration.

In terms of a self-reported diagnosed mental health issue, 12 participants indicated that they did not know their diagnosis. Of those who reported a diagnosis, 12 reported having schizophrenia, with an additional six reporting schizophrenia plus either bipolar disorder, depression or anxiety. Two reported bipolar disorder as their main diagnosis; one reported depression and two reported anxiety as their main mental health issue.

Data from the 35 OSA questionnaires were compiled to form a priority profile of living skills. Descriptive statistics were used to obtain frequency counts on skills perceived as challenging by the prisoner group, and which skills were perceived to be most important. The researchers were in a position to examine the trends in terms of priorities for skill development, and hence to establish the profile of skill-development priority for the participants. These skill development priorities are presented in Table 1. Overwhelmingly, the skill of ‘working towards my goals’ was the item most frequently identified as most important but most difficult to perform. The significance of living skills is qualitatively supported by comments from participants. For example, these included:

The last time I got out, I said to myself ‘I’ve done my time, now what?’ This time, I won’t know where to start either.

I’m no good with money, that’s my problem.

I thought I was on top of things, got my housing organised… but I didn’t look after the place… now I’m back in here.
### Discussion

**On the Inside: the case for pre-release preparation**

All participants engaged in discussion on the value of living skills in re-establishing a life beyond prison. Setting meaningful goals was identified by participants of this study as the most important skill to acquire in preparing for this transition but, in turn, participants identified a lack of opportunities offered to develop skills in competent goal-setting or proactive choice-making. For example, participants commented that:

*Making goals, that’s easy. Abiding to them is a different story.*

*I never stick to my plans, something always gets in the way.*

Yet society expects change in behaviour from those incarcerated on their return to the community. This reveals an interesting picture: participants identifying the need for change and learning opportunities, society expecting changed behaviour, and a prison system that, by design, holds its interns in a status quo.

Many international correctional systems advocate moving from the traditional approach of safe-custody to one of rehabilitation (Howells & Day, 1999; Howells et al., 2004). Current debate in Australia focuses on how to best incorporate rehabilitation principles into the justice system, and into custodial operational philosophies (Howells et al., 2004). This includes addressing the needs of vulnerable groups, such as people with mental health issues in prison (Victorian Department of Health, 2009). For this group, the ability to make choices, learn new skills and develop self-awareness of personal values, strengths and weaknesses, are paramount to optimal transition to the community and reducing risk of recidivism.

Furthermore, it is noteworthy that over 33 per cent of participants in this study were unaware what diagnosis they had been given. Successful transition to the community requires the person to set realistic goals, incorporating a clear understanding of their mental health, their triggers, patterns and early warning signs. Understanding diagnosis is clearly an aspect of self-management of mental health. Stable mental health is a protective factor that reduces the risk of re-offending (Victorian Department of Health, 2008).

Results of this study suggest the case for pre-release rehabilitation with due emphasis on living skills, particularly the skill of goal-setting, is essential, as is the opportunity to learn mental health self-management strategies. The participants in this study appear to concur with this position.

### Table 1 – Skill priority list ratings

<table>
<thead>
<tr>
<th>Skill priority list based on ratings of 35 participants</th>
<th>OSA: Living skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Working towards my goals</td>
</tr>
<tr>
<td>2</td>
<td>Getting done what I need to do (daily routine)</td>
</tr>
<tr>
<td>2</td>
<td>Managing my finances</td>
</tr>
<tr>
<td>3</td>
<td>Doing activities I enjoy</td>
</tr>
<tr>
<td>3</td>
<td>Effectively using my abilities</td>
</tr>
<tr>
<td>3</td>
<td>Accomplishing what I set out to do</td>
</tr>
<tr>
<td>4</td>
<td>Taking care of myself</td>
</tr>
<tr>
<td>4</td>
<td>Expressing myself to others</td>
</tr>
<tr>
<td>5</td>
<td>Managing my basic needs (food, medicine)</td>
</tr>
<tr>
<td>6</td>
<td>Taking care of the place where I live (e.g. house-keeping)</td>
</tr>
<tr>
<td>6</td>
<td>Concentrating on daily tasks</td>
</tr>
<tr>
<td>7</td>
<td>Making important decisions based on what I think is important</td>
</tr>
<tr>
<td>8</td>
<td>Physically doing what I set out to do</td>
</tr>
<tr>
<td>9</td>
<td>Handling my responsibilities</td>
</tr>
<tr>
<td>10</td>
<td>Taking care of others for whom I am responsible (e.g. family)</td>
</tr>
<tr>
<td>11</td>
<td>Being involved as a student, worker, volunteer, and/or family member</td>
</tr>
<tr>
<td>12</td>
<td>Getting where I need to go (e.g. appointments, programs)</td>
</tr>
</tbody>
</table>
On the outer: the case for ‘wrap-around’ support

In line with previous research with this population (Hendersen, 2007), participants in this study explained just how challenging the transition to the community can be. Comments included:

In this place, there’s a set routine, and a lot’s done for you… three meals a day handed to you. Then you get out and you’re doing it all yourself.

Inside, it’s easy to say what I should do better. Out there, it’s hard, there’s too much chaos and too much going on in my head.

The person can be faced with the real-life challenges of transition, compounded by a service system that struggles to respond to their needs. The current Victorian Mental Health Reform Strategy (Victorian Department of Health, 2009) identifies the need to build community-based forensic capacity. Partnerships between the PDRSS and the clinical mental health sector will need to develop shared strategies to work with people with forensic histories (Victorian Department of Health 2008), and also strengthen collaboration to achieve better outcomes, particularly for clients with challenging behaviours. Service providers need to ensure that forensic histories, or historical risk factors relating to aggression, do not become barriers to accessing mental health services when there is a need. Post-release supports that address the broad range of needs, including health, housing and employment, have proven effective in reducing risk of recidivism by up to 70 per cent, and are highly cost effective by comparison to imprisonment (Department of Health, 2008).

Protective factors that reduce the risk of re-offending include stable mental health, stable housing, reduced substance use and meaningful occupation. The PDRSS sector will need to step up to leadership roles in the development of partnerships that can facilitate making the ‘wrap-around support’ concept a reality.

The PDRSS sector is placing emphasis on building workforce capacity to work with people at risk of offending. Anecdotally, this includes capacity in identifying and managing risk and challenging behaviour, as well as capacity to coordinate management and prevention plans. The findings of this study suggest the need for the sector to build capacity to address living skills, as this is a real and current need for our clients with forensic histories and those at risk of coming into contact with the criminal justice system. The experience of Western Region Health Centre (WRHC) in building the capacity of staff in addressing skills, and the potential of learnings to be shared across the sector, is explained below.

Building the capacity of the PDRSS sector to address living skills

A core element of psychosocial rehabilitation is working alongside consumers towards meaningful goals. Frequently, these goals focus on aspects of the person’s living skills.

I can think of a few living skills I’d need help with, to get me on my feet when I get out of this place: cooking, for sure. I don’t look after myself well.

The process of developing living skills can be complex and unique to the needs of the individual. The individual may have multiple issues, such as substance use, acquired brain injury or intellectual disability, in addition to their mental health issues. In recognition of this complexity, WRHC developed a Living Skills training package that builds the skills and understanding of staff working with clients to address their living skills. The Living Skills package incorporates a comprehensive Guide to Living Skills Assessment and Intervention, and Living Skills training delivered via an interactive workshop. The Living Skills Guide was developed in 2008 in response to a survey of PDRSS and assertive outreach staff, which indicated that the majority of staff assess and support clients with their living skills and believe they would benefit from education in this area (Guide to Living Skills Assessment and Intervention, 2008). The package aims to provide workers with systematic ways of assessing living skills, and providing interventions targeting living skill development.

The assessment component of the package enables the worker to identify what skills require attention. In this way, the training can be tailored to individual needs, increasing the person’s participation and motivation (Nemec et al., 1992; WRHC Guide to Living Skills Assessment and Intervention 2008). The intervention strategies component of the Living Skills package draws on adult learning principles and describes a range of techniques for use with individual clients such as enabling, verbal and written prompting, and grading. The
preferred learning style of the person will influence what strategies work best for an individual, and recognising the person’s learning style is important (Guide to Living Skills Assessment and Intervention, 2008).

The Living Skills training interactive workshop has been rolled out across WRHC’s mental health and assertive outreach programs, with positive results to date. It has also been made available to the PDRSS sector, via a partnership with VICSERV’s training and development team. The training is undergoing evaluation and is included in the 2011 VICSERV training calendar.

Additional strategies to enhance mental health workforce capacity in living skills in 2010, included the employment of an occupational therapist, and the provision of a creative goal-setting workshop to staff. The employment of an occupational therapist with expertise in the interaction of the person, environment and living skills, served to diversify the skill-set of the workforce and enhance the living skill focus. The creative goal-setting workshop provided a forum to explore the challenges inherent in meaningful goal-setting with clients, and offered a range of creative strategies to consider when approaching this task.

In conclusion, the response to ‘I’ve done my time, now what?’ is potentially a question that the PDRSS sector, in collaboration with partners, will answer with increased confidence and capacity.

VICSERV can provide this article with its full list of references. To request a copy, please contact Kristie Pate on 03 9519 7000 or k.pate@vicserv.org.au
Violence against people with cognitive impairments: a study by the Office of the Public Advocate

Magdalena McGuire, Legal Policy and Research Officer, Office of the Public Advocate

Consistent with the broader research on family violence, the majority of these cases related to violence against women (66 cases). A broad range of cognitive impairments are represented within the case studies, with intellectual disability being the most common primary diagnosis (41 cases). In some cases, it was noted that the violence resulted in the person sustaining additional impairment/s, such as a traumatic brain injury or a mental illness.

Through its advocacy and guardianship work, the Office of the Public Advocate (OPA) is frequently involved with people with cognitive impairments who experience violence. In response to this issue, Janine Dillon, an Advocate/Guardian at OPA, undertook a project that investigated the circumstances of OPA clients who experience violence, and explored the responses of service providers to these incidents of violence. This article offers an overview of the report, and highlights the impact of the report to date.

OPA’s mission is to promote the rights and interests of people with disabilities, and to work towards enabling people with disabilities to live lives free of abuse, neglect and exploitation. This mission is met through work conducted by OPA in a range of areas, including systemic advocacy and research, a community information service, three volunteer programs and the Advocate/Guardian Program.

In late 2009, Janine Dillon commenced a project that explored the incidence of violence against people with cognitive impairments who had been clients of OPA’s Advocate/Guardian Program. Janine’s project was exploratory in nature and was undertaken over a 12-week period. The tight timeframe of the project precluded a comprehensive analysis of all OPA’s records relating to violence. Instead, Advocate/Guardians were asked to volunteer information about cases in which they had represented a person who was a victim of violence. In response to this request, 14 Advocate/Guardians provided information about 86 cases involving people who had experienced violence. An allegation of violence was sufficient to enable a case to be collected as part of this research; there was no requirement that the incident of violence be substantiated (which, in part, is a reflection of the difficulties that can exist in proving that violence against a person with a disability has occurred).
The data from the 86 cases forms the basis of the report, Violence against People with Cognitive Impairments: Report from the Advocacy/Guardianship Program at the Office of the Public Advocate, Victoria. This report explores case studies involving violence against people with disabilities aged 16 to 100+. Consistent with the broader research on family violence, the majority of these cases related to violence against women (66 cases). A broad range of cognitive impairments are represented within the case studies, with intellectual disability being the most common primary diagnosis (41 cases). In some cases, it was noted that the violence resulted in the person sustaining additional impairment/s, such as a traumatic brain injury or a mental illness.

Advocate/Guardians involved in this research reported that their clients had been subjected to a range of violent and abusive acts, including physical and sexual violence, emotional and psychological abuse (such as seclusion and isolation), impairment-related abuse (such as denying a person their mobility aid), financial abuse, and neglect. Most clients had been subjected to more than one form of abuse (50 cases). Fifty-two of the clients involved in the case studies were reported to have experienced physical violence. Women clients, in particular, reported a high rate of sexual violence (this was reported in 30 of the 66 cases involving women).

Perpetrator categories included the client’s parent or parent’s partner, sibling, adult child, other relative, partner, neighbour, staff, co-resident, and stranger. Overall, there were 64 cases in which perpetrators were categorised as relatives and partners, meaning that their actions may be classified as family/domestic violence within the definitions of the Family Violence Protection Act 2008 (Victoria). In spite of this, the rates of involvement of family violence services were reported to be low. Likewise, Advocate/Guardians reported cases of people with disabilities disclosing abuse and not receiving an appropriate response in relation to the criminal, social and emotional aspects of the disclosure. Within the cases studied, it was also evident that, for some people, risk factors for experiencing further violence had been identified but were not acted upon. For example, there were several examples within the cases studied of clients of the Department of Human Services who remained in inappropriate housing and, consequentially, experienced further violence and/ or continued to exhibit behaviours of concern.

Overall, the cases studied in the report indicate that there needs to be greater coordination between disability and legal services in order to achieve better outcomes for people with disabilities experiencing violence. In response to the issues raised in the report, OPA has sought the following changes:

• greater support for people with cognitive disabilities to make complaints of violence, and ensure their complaints are appropriately dealt with by the criminal justice system
• more responsive services that offer immediate protection, including provision of alternative accommodation, when violence against a person with a cognitive impairment is disclosed or suspected
• improved prevention initiatives, including better public education, improved reporting of inappropriate or dangerous behaviour, and more risk-conscious housing decisions.1

The report on disability and violence demonstrates that concrete data on violence against people with disabilities can have a significant impact on the Victorian political and social milieu. The release of the report resulted in considerable media attention, including an article on the front page of The Age, a strong Age editorial, and follow-up interviews on ABC radio. The new Minister for Mental Health, Women’s Affairs and Community Services responded very favourably to the report, with a commitment to an industry reform in April and a parliamentary inquiry into the contact that people with intellectual disability have with the criminal justice system.2

It is clear, however, that much work still needs to be done to ensure that people with disabilities are able to achieve and enjoy their human rights. Since the publication of the report in August last year, OPA has received ten notifications of sexual assault or serious violence against a person with a disability. Likewise, OPA’s Independent Third Person Program statistics show that 272 victims of sexual assault attended a police interview with an Independent Third Person in the last financial year – twice that of a decade ago. Violence against people with disabilities is a priority area throughout all OPA programs. Staff and volunteers at OPA continue to promote the right of people with disabilities to live lives free of violence, and we look forward to some real change for vulnerable Victorians as a result.

References
1 Office of the Public Advocate, Violence against People with Disability: Public Advocate Calls for a Major Change, [media release] (28 January 2011)
2 The Hon. Mary Wooldridge MP, Coalition Welcomes Public Advocate Report, [media release] (28 January 2011)

FIND OUT MORE. To view the full report on disability and violence, visit the OPA website at: http://www.publicadvocate.vic.gov.au/research/255/
Co-designing mental health services – providers, consumers and carers working together

Karen Fairhurst, Project Officer, Carer Research and Evaluation Unit, Victorian Mental Health Carers Network (VMHCN)

Wayne Weavell, Project Officer, Consumer Research and Evaluation Unit, Victorian Mental Illness Awareness Council (VMIAC)

By providing a systematic and effective mechanism for gaining consumer and carer experiences of service delivery, the Consumer and Carer Experience pilot highlighted service ‘touch points’. Touch points are defined as those aspects of the service that consumers and carers identify as being the most or the least positive aspects of their experience with the service. The highlighted ‘touch points’ from the Consumer and Carer Experience surveys were then used to inform the Mental Health Experience Co-Design process.

Introduction
Involvement in mental health service planning, implementation and evaluation is a key feature of consumer and carer participation policy. This principle was highlighted by the Victorian Department of Human Services (2002), which published, as one of its core principles, the following statement:

The Government is strongly committed to consumer and carer participation in the development and review of mental health services, and the involvement of consumers and carers as active partners in individual treatment and care planning.

Mental Health Experience Co-Design (MH ECO) implements a research methodology that applies the theory and practice of Experience-Based Design (EBD) (Bate and Robert, 2007), in health service quality improvement. The primary goal of the EBD approach is to engage consumers, carers and service providers in actively working together to co-design features of service delivery. In MH ECO, these features are identified through an analysis of carer and consumer experience questionnaires administered within the participating mental health service, semi-structured interviews and focus groups.

Development
MH ECO is a method of service quality improvement that has developed from the Consumer and Carer Experience of Care and Support pilot project (C&C Experience). The pilot project was initiated in 2006 by the Victorian Department of Health - DOH (formerly the Department of Human Services - DHS) as a means of improving the low participation and response
rates of mental health consumers and carers to satisfaction-based surveys. The C&C Experience pilot project trialled a new, mixed research design, in a number of clinical and PDRS mental health services, aimed at gathering data on consumers’ and carers’ experiences of care and participation. The data for the C&C Experience pilot was captured through structured questionnaires using Computer Assisted Telephone Interviews (CATI), face-to-face, semi-structured interviews and focus groups.

Identifying touch points
By providing a systematic and effective mechanism for gaining consumer and carer experiences of service delivery, the C&C Experience pilot highlighted service ‘touch points’. Touch points are defined as those aspects of the service that consumers and carers identify as being the most or the least positive aspects of their experience with the service. The highlighted ‘touch points’ from the Consumer and Carer Experience surveys were then used to inform the MH ECO process.

In practice, the three most positively rated and the three least positively rated service aspects from the C&C Experience data analysis process were identified for examination. As Doutta Galla Community Health was one of the services participating in the C&C Experience, the MH ECO project, undertaken at Doutta Galla, utilised the C&C Experience data to determine the touch points used to inform service quality improvement processes.

MH ECO project stakeholders
MH ECO at Doutta Galla Community Health, involved the following stakeholders:

- Doutta Galla Community Health, Mental Health and Complex Needs Programs
- Doutta Galla Community Health
- Victorian Mental Illness Awareness Council (VMIAC)
- Victorian Mental Health Carers Network (VMHCN)
- the Mental Health and Drugs Division of the DHS
- clients of Common Ground Day Program and Rocket Youth Residential Program at Doutta Galla
- carers of clients of Common Ground Day Program and Rocket Youth Residential Program at Doutta Galla.

The engagement of relevant champions and support from senior executives that links back to the normal management processes within the organisation (Bate and Robert, 2007), were key factors to the overall success of the project.

Project objectives
The primary aim of the Doutta Galla MH ECO project was to develop capacity in Doutta Galla’s Mental Health services for incorporating experience based co-design processes into organisational quality improvement practice. Specific quality improvement objectives (1, 2 and 3 listed below) were derived from the touch points identified in the C&C Experience pilot project (Doutta Galla Service Report, 2008) with objectives 4 and 5 being added at the project planning stage by the project Liaison Group, which was established at the start of the MH ECO project.

The MH ECO project objectives were as follows:
1. To re-design the way in which consumers and carers are informed about what they can expect from participating in the psychiatric disability rehabilitation and support services at the Common Ground Day Program at Doutta Galla.
2. To re-design the way in which consumers and carers are informed about the feedback and complaints management process in the Common Ground Day Program at Doutta Galla.
3. To re-design the way in which carers can be supported in their role, which may include a better understanding of the challenges faced by people with mental illness, better fulfilling of their carer role, and making decisions regarding the role they wish to take in supporting their loved one with mental illness at the Doutta Galla Rocket Youth Residential Program.
4. To evaluate the effectiveness of the MH ECO methodology in achieving improvements in program specific service delivery (as described above).
5. To increase the collaboration and service re-design skills of staff, consumers, and carers who are involved in the project.

The primary criteria for the first three objectives were that the service features to be redesigned had scored a low positive response rate on the C&C Experience CATI questionnaire, and had also figured prominently in interview and focus group thematic analyses. The fourth objective was built into the project brief in order to evaluate the MH ECO methodology in a program specific setting. The fifth objective was viewed by both the Project Teams and the Department of Health (DOH) as being important in building capacity within the participating service organisation, which is a fundamental feature of the MH ECO methodology.
Prior to the formation of the Mental Health Experience Co-Design Collaboration and Co-Design groups, training sessions for the consumers, carers and staff of the participating service were conducted by members of the research teams. The training education sessions (developed by the research teams) aimed at enabling consumers, carers and staff to feel comfortable, supported and included as participating members of the Collaboration and Co-design groups.

The Role of the Project Team
The Consumer and Carer Project Team consisted of project workers from both the VMIAC and VMHCN Research and Evaluation Units. The teams acted as an external resource to the service and provided on-the-ground support and methodological assistance throughout the MH ECO process. However, it is important to note that the responsibility for leadership and overall governance of the project rested with Douutta Galla management and not with the combined Consumer and Carer (MH ECO) Project Team. The Consumer and Carer Project Teams assisted and supported the Douutta Galla MH ECO project in the following manner:

- promoted MH ECO to the service executive to enlist their leadership
- promoted MH ECO to consumers, carers and staff members at the service
- facilitated a staff focus group in response to the items that were identified by C&C Experience (pilot project)
- involvement in the establishment of the MH ECO Collaboration Group
- provision of training and support in the MH ECO process to staff, consumer and carer representatives through two education workshops held at the service
- being support members of the Collaboration and Co-design groups
- supporting the implementation process of the new designs
- reporting of MH ECO project progress to the DOH.

Through these steps, the Project Team was able to establish relationships with key stakeholders and engage them in the project, while simultaneously enabling the stakeholders to maintain ownership of the co-design process.

Establishing collaborative practice
Prior to the formation of the MH ECO Collaboration and Co-Design groups, training sessions for the consumers, carers and staff of the participating service were conducted by members of the research teams. The training education sessions (developed by the research teams) aimed at enabling consumers, carers and staff to feel comfortable, supported and included as participating members of the Collaboration and Co-design groups.
In the initial training session, research staff from VMIAC and VMHCN worked with consumers and carers only in order to share their prior experiences of group processes. The training involved:

- a discussion of group process and function and an exploration of how participants felt with respect to participating with staff on an equal basis, (given that previous experiences may have involved a power differential, where the staff member was perceived as the expert)
- assisting the prospective participants in gaining some background understanding of the C&C Experience phase of MH ECO, i.e. how information about Doutta Galla was gathered and analysed
- building participants’ confidence for participation in the upcoming Collaboration and Co-design group meetings.

An intended outcome for the second combined session was the building of a collaborative ethos among the participants. The achievement of this outcome was evidenced by the fact that consumers, carers and staff did work together in a mutually respectful and productive manner in both the Collaboration and Co-Design group settings. In the second training session, the focus was to:

- provide an explanation of the constructs of Collaboration and Co-Design groups
- model working together in ‘hypothetical’ Collaboration and Co-Design groups
- organise the membership of the two groups
- select the most effective times for participants to meet in the two groups.

The sessions were held a week apart at a convenient time that was intended to facilitate the attendance of consumers, carers and staff. This meant that the sessions were held at the service in the evening, which did result in a sufficiently large number of potential participants attending. Feedback obtained through an evaluation form filled out by 14 participants at the end of the second session indicated that over 90 per cent of the participants felt that the education and resources provided were useful and relevant to their needs. At the end of the Co-Design group process, participation in the training sessions was highlighted by many participants as a key component contributing to the successful implementation of MH ECO.

**MH ECO in action**

The major milestones of the MH ECO project at Doutta Galla service were:

- formation of the Liaison group
- establishment of the Collaboration group
- formation of the Co-Design groups
- inclusion of action plan elements into the organisation’s quality improvement processes.

The project Liaison group oversaw the project and met monthly. The group consisted of the General Manager of Doutta Galla’s Mental Health Programs, the Project Co-ordination Officer at Doutta Galla, the Quality Manager, a Senior Project Officer from the DOH, and the Project Managers of the consumer and carer Project Teams. In practice, the Liaison group ensured fidelity to the MH ECO methodology, monitored progress of the project and assisted in the evaluation of the project.

**Collaboration group**

The initial function of the Collaboration group was to analyse and discuss the touch points that had arisen from the Doutta Galla C&C Experience data. Once this was completed, the second task was to formulate, prioritise and then allocate the objectives to three Co-Design groups (see next section). The philosophy used in the decision-making process was that the objectives were to be realistic, achievable and measurable. At the end of the Co-Design group process, (see next section), three action plans were relayed back up to the Collaboration group, which then performed its third function of co-ordinating the Co-Design group proposals, which were then formulated into comprehensive, actionable quality improvement plans.

The Collaboration group was comprised of representatives of senior Doutta Galla staff (including a staff member appointed as the Project Coordinator for the service), consumers, carers, research workers and consumer and carer consultants who met at the start and end of the Co-Design process as well as at two follow-up meetings three months apart. The first follow-up meeting assessed the initial outcomes of the recommended quality initiatives and the second follow-up meeting was organised to provide feedback to participants of the progress of the quality improvement activities. The feedback was very positive and encouraging illustrating the value of the project to the organisation and its consumers and carers.
The Co-Design groups

Three Co-Design groups were formed at Doutta Galla, each of which had the goal of producing an action plan for the re-design objective that it had been allocated. The groups met three times, with meetings a fortnight apart and consisted of representatives of staff, consumers, carers, research workers and, consumer and carer consultants. The meetings of each Co-Design group followed a progressive pattern of activity.

The first meeting discussed and mapped the current processes involved in the service area that they were assigned to redesign. The process mapping exercise often provided new and valuable insights for participants, who were able to better conceptualise the service area through being informed by the multiple perspectives presented by group members.

The second meeting of each Co-Design group investigated examples of good practice that were sourced by the research teams and the Doutta Galla MH ECO Project Coordinator. In the third meeting, the Co-Design groups developed their action plans based on the group’s previous analysis of current service activities and examples of good practice.

The MH ECO Project Coordinator collated each of the Co-Design groups’ action plans for presentation to the second Collaboration group meeting. It was then the Collaboration group’s task to analyse and recommend actions for inclusion into the organisation’s quality improvement framework. The research teams from the VMIAC and the VMHCN each supplied a project worker to the Collaboration and Co-Design groups to act as facilitators and mentors in the co-design process. The project workers played an integral part in the MH ECO co-design process through their support, facilitation and expertise in group dynamics.

Conclusion

MH ECO is an innovative quality improvement methodology based on utilising the experiences of consumers, carers and service staff. At Doutta Galla, the C&C Experience pilot project identified the consumer and carer experiences from which the touch points for the co-design process were identified and the subsequent development (through the process of collaboration and co-design) led to the development of detailed action plans that resulted in realistic and meaningful quality improvements. The project also introduced the co-design philosophy into the organisation and resulted in the up-skilling of Doutta Galla service staff in the methodology, thereby building capacity for application in future quality improvement activities.

Doutta Galla demonstrated a high level of commitment to both leadership and ownership throughout the project and in return, the MH ECO process fulfilled its potential of enhancing service and ultimately improving stakeholder experiences.

References

Bate, P. & Robert, G. (2007) Bringing User Experience to Healthcare improvement, the concepts, methods and practices of experience-based design, Radcliffe, Oxford


YOUR SAY...
Opinion piece
Strengths… time for a rethink?

Maggie Maguire, Mental Health Consumer

Other people have said that my attitude to the strengths perspective is different, but if you think about most mental illnesses, the actual manifestation of the illness is nearly always either ‘strengths used in excess’ or ‘strengths used out of context’. Learning to recognise and moderate those excesses and inappropriate behaviours is perhaps the most important part of staying well.

In July 2010 the Tasmanian Commissioner for Children, Paul Mason, raised a small red flag over the ubiquitous Strengths Perspective. In his Report on the role of the Tasmanian Child Services in a tragic incident of a mother prostituting her 12-year-old daughter, Commissioner Mason said:

The title of the Report ‘She Will Do Anything To Make Sure She Keeps The Girls’ is a sentence from a list of strengths relied on to justify a recommendation that it was now safe to let a time-limited 12-month guardianship order lapse in October 2009. That strength was a weakness.

Commissioner Mason correctly identified a serious problem with the use of the strengths perspective when working with people with mental health issues; that strengths for people with mental illness often also contain the seeds of some of the worst aspects of the illness.

When I was first in rehabilitation and was asked what my strengths were, I had great difficulty answering the question mainly because while tenacity, determination and confidence were my main strengths, when I was ill they were also my greatest weakness. For example, having tenacity meant that I could hold on to seriously damaging delusions for some six years.

The same can be said for most mental illnesses. For instance, if you asked someone with anorexia what their main strengths were they would probably list self-discipline, self-control and determination. However, would realising that list of strengths really help that person recover? By asking mental health consumers to describe characteristics as strengths without admitting the possibility that they are also weaknesses, isn’t the worker at risk of reinforcing problem behaviour?

Similarly, problems may arise because the strengths experienced when a person is undergoing psychosis for example, are not necessarily able to be translated into ordinary life when they are recovering. Another example might be when a case worker is encouraging a client to perhaps go outside their comfort zone...
and use public transport, asking them to ‘tell me about your strengths when you joined the Foreign Legion.’ Let’s say the client identified with the strength ‘courage’ when using public transport. The person may also think, ‘yes, I was very brave when I joined the Foreign Legion, but I was also very brave when I stood on the edge of that skyscraper imagining I was a leaf.’ Therefore the general feeling may be one of confusion.

Generally in my experience, after some 30 years with bipolar schizoid affective disorder disrupted by psychotic events, there is not the continuity of experience and emotions throughout the life span that would allow a person to draw strength or empowerment from previous events. In fact, the main reason I envy ‘normal’ people is because they have a certain continuity of experience.

However, for all people, all strengths used in excess are weaknesses. A mother who loves her child to the degree she ignores discipline is exhibiting weakness. As well as this, all strengths used out of context are also weaknesses. For instance, it is a great strength to be entertaining but a weakness to tap-dance in Church. I feel that the rather formulaic way in which the Strengths Perspective is used in mental health programs is really quite inappropriate as it ignores important aspects about strengths. I will go so far as to say that the Strengths Perspective should not be used at all when working with people with mental health issues without considerable reference to the problems that occur when strengths are used either in excess or out of context. However, as I am aware that discussing ‘problems’ is somewhat out of vogue, I therefore propose a skills-based alternative.

If someone asks me what my skills are, none of the problems that arise with the use of the word ‘strengths’ exist. I can list them very easily and without any confusion: I cook well, I can knit and sew, I make great conversation, I can swim expertly.

Strengths are rather vague, and include feelings like optimism, determination and consideration, which sometimes I have in excess and sometimes not at all; sometimes they’re good to have, sometimes they’re bad depending on the context. Skills are concrete and once you have them you don’t lose them even if you become mentally ill (I can play the piano, I can sing, I can dance.)

Skills such as typing 80 words a minute, swimming and painting are also value-free, whereas strengths are value-loaded. Being ‘considerate’ may be something a person with Aspergers Syndrome may never contemplate as being a good thing. ‘Independence’ is, culturally, a value-loaded word and does not necessarily mean the same thing to all people in all societies. There are times when being ‘independent’ can be good and times when it can be damaging.

People who have a serious mental illness often have extraordinary skills in other areas of their lives. These specialist skills could be in areas such as photography, art, music or the natural world. Sometimes the driver for these skills is that there is some relief from the constant ruminative thoughts that arise with mental illness. These skills (and the projects that derive from them) are much more important to people with serious mental illness than vague strengths, yet very often skills are ignored and neglected in Strengths Perspective-based programs. People with these skills require support to carry them to the next level. Often this support is really quite inexpensive and simple, e.g. having access to computers, the internet, photocopiers and telephones and linking up with mentorship.

I hate to use the term ‘rabbiting on’, but the continual emphasis on strengths when the perspective has the problems listed above often leads to disappointment and frustration by the consumers who may have the most serious symptoms of mental illness but the most fantastic skills. I know that some consumers extol the virtues of the strengths-based approach and I think it does have some positive aspects for people such as young women whose strengths may have traditionally been repressed. However, even in this situation, I think the Strengths Perspective should be translated into skills. Perhaps the skills associated with taking public transport safely (e.g. self-defense skills) could be taught directly to the person rather than having a deep and meaningful discussion on personal strengths. This way the concept is not lost in a vague wash of words and the disturbing introspection that often results will no longer be the case.

Other people have said that my attitude to the strengths perspective is different, but if you think about most mental illnesses, the actual manifestation of the illness is nearly always either ‘strengths used in excess’ or ‘strengths used out of context’. Learning to recognise and moderate those excesses and inappropriate behaviours is perhaps the most important part of staying well.

Maggie Maguire is a mental health consumer of some 37 years. Having teacher training she is interested in the application of educational theory and research to psychosocial rehabilitation. She is currently studying to be a nutritionist and blogs on mental health issues on her website ‘Stop Thrashing Around’ at: www.stopthrashingaround.wordpress.com

References

Member profile

Australian Community Support Organisation (ACSO)

Specialist Mental Health Services overview – keeping the door open

Robb Ritchens, Specialist Mental Health Services Manager, ACSO

The Specialist Mental Health Services team recognises that despite our efforts, service users often relapse, resulting in offending and prison. Therefore, we view our relationship as a stop-over on their journey. We pride ourselves on the door-always-open approach and continuously take on the same client multiple times, even when their offending is sometimes aimed at us.

ACSO have been assisting the disadvantaged for 25 years, connecting them with the supports they need to improve their lives.

For 19 years, Specialist Mental Health Services (SMHS) has been servicing men and women with substantial psychiatric issues that lead to marginalisation and incarceration. SMHS consumers experience isolation, substance abuse, unstable mental health and homelessness, all of which influence their behaviour resulting in criminal justice involvement.

The SMHS suite of programs assists service users to transition from a custodial setting back into the general community. Our programs are voluntary and attempt to give back some control to people who are often under several forms of mandatory orders.

We typically engage people through the correctional system and attend the entire Victorian prison system and assess and plan for a successful return to community life. Our service users typically have multiple barriers impacting on their ability to access and maintain services including stable housing and treatment options. Our programs adopt a holistic approach, which requires our workers to be knowledgeable in the areas of mental health pathology, treatment, housing and homelessness and the legal system.

Program participation is voluntary and focuses largely on welfare. The service delivery model incorporates prison in-reach, outreach and supported housing. SMHS delivers intensive outreach for women with a diagnosis of borderline personality disorder who are generally unable to establish and maintain personal and professional relationships and, typically, cannot access clinical case management.
To complement our support model we have recently gone into partnership with Yarra Community Housing to establish Yarra Space, a fully-staffed accommodation foyer model. The SMHS McCormack workers promote integration through onsite support and psychosocial programs that foster community connections, reduce isolation and build better relationships between residents and their local community.

SMHS have also long recognised the importance of supporting the families that are often left damaged from the consequences of mental illness and related offending behaviour. SMHS’s Restore Program is a new initiative that provides support to such families and is often a parallel and complementary service to our other programs, although it also supports families that do not have another family member involved with SMHS.

The SMHS team recognises that despite our efforts, service users often relapse resulting in offending and prison. Therefore, we view our relationship as a stop-over on their journey. We pride ourselves on the door-always-open approach and continuously take on the same client multiple times, even when their offending is sometimes aimed at us. The following case study says it best:

Twenty-two-year-old Jimmy was referred to SMHS pre-release. His undiagnosed mental illnesses led to him committing a tragically violent offence. Over several chaotic years, SMHS remained Jimmy’s only support, despite his maladaptive and anti-social behaviours including drug related offending and non-compliance.

Jimmy’s tendency to integrate workers into his delusions, especially when they were initiating crisis services, led to violent outbursts and property damage. The SMHS team understood that Jimmy’s behaviours were symptoms and his non-compliance was driven by many losses and denial of his diagnosis of schizophrenia.

The key to Jimmy’s eventual success was trust, flexibility, commitment and a strong collaborative approach with services including clinical services, Alcohol and Other Drugs services, mental health and forensic services and corrections. SMHS remained connected using the SMHS out-of-hours contact service, assertive in-reach and outreach well beyond the usual geographical boundaries.

Eventually, Jimmy stabilised and through ACSO’s Disability Employment Service he gained employment and SMHS secured nominated long-term accommodation. Jimmy now lives a full life, is in a stable relationship and in his spare time he helps others through volunteer work.

This study demonstrates how keeping the door open, despite the bricks being projected through it, does work when assisting high needs clients with major barriers to social integration.
**Expression Session**

**Artist’s statement about this painting (opposite):**

‘Much of my work features faces that are ambiguous, suggestive of a loss of language and personality in times of illness. The chain is symbolic of constraint and the pills refer to one means of constraint.’ **Donna Lawrence**

See Beyond This 2006  
oil and acrylic on canvas  
110 x 100 cm  
Cunningham Dax Collection

A selection of Donna Lawrence’s works will be included in the upcoming exhibition: Melancholia, at the Dax Centre. The exhibition will be open from 21st April 2011 until October 2011. The exhibition explores themes of depression and creativity, the art historical discourse of melancholia, the visual language of melancholia, and the experiences of the artists with melancholic inspiration.
Artist profile
Donna is an award-winning practicing artist who has exhibited regularly over the past 15 years and has been involved in a wide variety of community arts festivals and projects. Donna’s work reflects themes of catharsis, isolation, prejudice and language.

Artist’s statement
'I believe visual artwork can be aesthetically pleasing as well as politically motivated or intellectual. I aim for both of these elements in my work.

I believe artwork can be empowering in its shared meaning as opposed to simply its aesthetic qualities. It can allow some people to feel a significant adherence to a group of similar minded/experienced people, and lead others to experience empathy and gain knowledge, concerning the occurrences of others. Similarly, I hope that my work will reach people who have experienced mental illness, and people who have not. It is ultimately an issue that affects us all.'

About the Cunningham Dax Collection
The Cunningham Dax Collection, amassed over a 70-year period, consists of over 15,000 artworks including works on paper, photography, paintings, sculptural work, journals, digital media and videos created by people with an experience of mental illness and/or psychological trauma. The Cunningham Dax Collection is part of the Dax Centre.

The Dax Centre promotes mental health and wellbeing by fostering a greater understanding of the mind, mental illness and trauma through art and creativity.

For more information on the Cunningham Dax Collection and the Dax Centre, visit: www.daxcentre.org
This book proved to be excellent holiday reading for a policy wonk like me. Recent developments in outcome measurement (OM) from around the world are brought together in a single source. The fact that many of these developments have occurred in Australasia makes the book particularly relevant to local practitioners. Australia is regarded as a world leader in the field and it is fitting, therefore, that one of the chapters is written by VICSERV Board Member and Neami Victorian State Manager Glen Tobias on OM in NGOs.

Early in the book, the point is made that according to national outcome data, in the main, consumers in contact with Australian public-sector mental health services get better (p.17). However, the rest of the book suggests that this is by no means a simple claim. How are outcomes in mental health defined? Who defines what a ‘good’ outcome is? Can outcomes be attributed to particular interventions? Why collect outcome data? How can consumers’ perspectives be incorporated? These are all questions that countries around the world have grappled with. The first section of the book contains accounts of OM in Australia, New Zealand, Canada, Germany, Italy, Norway, the United Kingdom and the United States. From reading these varied approaches, it seems that for OM to be successful, it requires distinct policy and legislative direction, adequate resourcing and strong local leadership.

The second section of the book is devoted to OM in specific groups and settings. Chapters cover the various age groups, private hospitals, indigenous health, NGOs and drug and alcohol settings. Glen Tobias’ chapter highlights problems within the Australasian community managed mental health sector who are not mandated to report on data and who use several different tools when it is collected. This precludes the possibility of benchmarking and service system planning on a macro level. Glen gives some practice examples where good things are happening at the local level, especially between the community managed mental health sector and the clinical sector. Obstacles to more routine use of OM in the sector are also discussed. The chapter concludes with a call for strong leadership to drive organisational change and for government funding departments to mandate a uniform system for Routine Outcome Measurement.

The final section of the book reviews a range of current issues in OM. Applications and utility, stakeholder perspectives, the assessment of change, workforce issues, the range of available instruments and the economic aspects of OM are covered.

The editor makes the point quite clearly that this is a book predominately written by clinicians and academics for clinicians and academics and that is why there are no chapters by consumers (p.8). Ouch! Clearly though, most of the authors had consulted consumers and carers and almost all advocate for their involvement to a greater or lesser extent in OM development and implementation. In a number of accounts, consumers were all for OM because it encouraged their clinician to stop and talk with them about their treatment and goals. Really rather simple isn’t it?

Reviewed by

Wendy Smith
Policy and Research Manager and newparadigm Editor, VICSERV
People with a serious mental illness such as schizophrenia have an average life expectancy that is at least 20 years less than other non-indigenous Australians. In this context, 50 to 59 years is equivalent to old age. The causes are many and mostly preventable. For the upcoming Winter edition of *new paradigm* we are seeking articles about the physical health status of people with mental illness and successful approaches to improving health outcomes.

We welcome submissions from workers and consumers in the mental health sector, GPs, physicians, academics, policy makers and anyone else interested in sharing their view on this issue.

Please note that the deadline for submissions is 1st June 2011.

For more information on *new paradigm*, including Contributor Guidelines and the remaining schedule for 2011, please go to [www.vicserv.org.au](http://www.vicserv.org.au)

---

Mental health laws exist in many countries to regulate the involuntary detention and treatment of individuals with serious mental illnesses. ‘Rights-based legalism’ is a term used to describe mental health laws that refer to the rights of individuals with mental illnesses somewhere in their provisions.

The collection addresses some of the current issues and problems arising from rights-based mental health laws. The chapters have been grouped in five parts as follows:

- historical foundations
- the *International Human Rights Framework* and the *United Nations’ Convention on the Rights of Persons with Disabilities*
- gaps between law and practice
- review processes and the role of tribunals
- access to mental health services

Many of the chapters in this collection emphasise the importance of moving away from the limitations of a negative rights approach to mental health laws towards more positive rights of social participation. While the law may not always be the best way through which to alleviate social and personal predicaments, legislation is paramount for the functioning of the mental health system. The aim of this collection is to encourage the enactment of legal provisions governing treatment, detention and care that are workable and conform to international human rights documents.

This book is based on research funded by an Australian Research Council Federation Fellowship.

Please contact the Resources Coordinator at VICSERV on 03 9519 7000 to borrow this book.
VICSERV is a membership-based organisation and the peak body representing community managed mental health 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 Prevention and Recovery Care (PARC) services.

Many VICSERV members also provide Commonwealth funded mental health programs.

**VICSERV envisages a society where mental health and social wellbeing are a national priority and:**

- Everyone has access to timely mental health treatment and support
- Mental health services are recovery oriented
- People participate in decision making about their own lives and their community
- People affected by mental illness have access to, and a fair share of, community resources and services
- All people are involved as equals, without discrimination.
As the peak body for the community managed mental health sector in Victoria, we pursue the development and reform of mental health services.

We support members by:

- Promoting recovery oriented practice
- Building and disseminating knowledge
- Providing leadership
- Building partnerships and networks
- Undertaking workforce development, training and capacity building
- Promoting quality in service delivery
- Undertaking advocacy and community education

Our Mission

Our Values

Collaboration (Teamwork)

- Working together to achieve shared objectives
- Respecting the knowledge and skills of others
- Putting the needs of the organisation above individual interests

Inclusiveness

- Listening to a range of views
- Representing and embracing the diversity of the sector
- Honouring the consumer and carer experience

Flexibility

- Proactively embracing change and new opportunities
- Stepping up and out from our roles and perspectives when required

Courage

- Taking leadership by speaking up on important issues
- Encouraging and supporting innovation
- Persistence in the face of obstacles and delays

Integrity

- Doing what we say we will do on time and to the best of our ability
- Listening and responding to members
- Having a respected voice and visibility in the sector, broader system and in government
- Being an honest broker of information and resources.
Membership Application Form

Name ____________________________________________

Organisation ____________________________________________

Street Address ____________________________________________

Suburb __________________________ Postcode ________________

Country ____________________________________________

Email ____________________________________________

Telephone __________________________ Fax __________________

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.

Please mail completed form to:

Membership
Psychiatric Disability Services of Victoria (VICSERV)
PO Box 1117, Elsternwick Victoria 3185 Australia

Or
Please fax completed form to: 03 9519 7022

Or
Apply for membership online at: www.vicserv.org.au

new-paradigm Autumn 2011
Psychiatric Disability Services of Victoria (VICSERV)
Subscription or Free Sample Copy

new paradigm

☐ Yes, I’d like to subscribe to new paradigm
☐ Yes, I’d like a free sample copy of the latest issue of new paradigm

Name
Organisation
Street Address
Suburb Postcode
Country
Email
Telephone Fax

Annual subscription: $80.00 (Inc. GST) Quantity
Individual back issues: $20.00 (Inc. GST) Quantity
* Consumers, students half price

Please mail completed form to:
new paradigm Subscriptions
Psychiatric Disability Services of Victoria (VICSERV)
PO Box 1117,
Elsternwick Victoria 3185 Australia

Or Please fax completed form to:
03 9519 7022

Or Apply for subscription to new paradigm online at:
www.vicserv.org.au

• Please note that we will issue a tax invoice and contact you accordingly, so there is no need to include payment.

Join Our E-Newsletter

factsline

factsline is our fortnightly e-newsletter, that keeps you up to date on all issues related to psychosocial rehabilitation and mental health issues. factsline includes announcements and updates and is available to all interested people and organisations.

Subscribe to factsline online at www.vicserv.org.au