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We begin this edition with an article from the federal Minister for Mental Health, the Honourable Mark Butler, MP where he sets down his hopes for the initiative Partners in Recovery (PIR). With the establishment of various consortia and tendering processes for the delivery of PIR, this issue is right on topic. Very similar to the care coordination initiative as it exists in Victoria, PIR looks to coordinate support for those with severe and persistent mental illness with complex needs.

Readers who attended the VICSERV conference may recall keynote speakers, Dr Kenneth Minkoff and Dr Christie Cline, the dynamic duo from the United States of America who spoke about creating welcoming services within the context of complex systems. Minkoff and Cline have delved further into this issue in their article where they outline the current failings of the service system that expects people to fit particular moulds rather than responding to who people are and what they want.

I am particularly excited to feature an article in this edition by Flick Grey and Merinda Epstein where they extrapolate the meaning of complexity and how it is often used as a euphemism to not address particular issues. Furthermore, they explore the concept of trauma and how one is defined and treated by the type and grade of trauma experienced. Sadly, the ranking of complexity as a way of justifying the allocation or non-allocation of resources is a reality. When I first heard Grey and Epstein present on this issue late last year, their message had a profound effect particularly in relation to my thinking around the concept of trauma. Indigo Daya also co-presented at that forum and has contributed to this edition by reviewing the book Secret Squirrel Business. I hope you find their message as powerful as I have.

As services move towards reform, organisations are ensuring they have the right linkages to assist people with their various needs more so than ever. This edition covers the whole gamut, including homelessness, compensable settings and the Multiple and Complex Needs Initiative. One area receiving focus is the youth space with a piece by Andrew Brunn and Penny Mitchell, an excellent article about some of the unique challenges faced by young people and ways in which services can engage with this group. So topical is the issue, with the recent release of the Cummins Report, that VICSERV will be hosting a forum specifically focused on how services can better engage with young people in early 2013. Look out for communications about this forum soon.

A theme that comes to the fore in many articles in this edition is that of people being in charge of their own treatment and care needs. Demos Krouskos explores what this could look like within a service. James O’Brien also gives an update on the National Disability Insurance Scheme, focusing on the state and federal negotiations around the pilot sites.

I hope you find this edition challenging and engaging. I also look forward to exploring many more issues around ‘Working with Complexity’ in future editions.
WORKING WITH COMPLEXITY
Partners in Recovery: new, practical support for people living with severe mental illness

The Hon. Mark Butler MP, Minister for Mental Health

The key principles of the implementation of Partners in Recovery are that it will be recovery oriented and client focused, flexible in its roll out, and complementary to existing service systems.

In a fast-paced modern world, keeping up with the demands of life can be a challenge for anyone. For people with severe and ongoing mental illness, and those around them, the challenge becomes much greater.

Mental health and other care and support services for people with mental illness can greatly reduce those difficulties, allowing people to recover and function as fully as possible within the community. Unfortunately, for many people with severe and persistent mental illness, with complex needs, finding the right mix of care and assistance is itself a major challenge.

This is about to change as a result of the Australian Government’s new initiative, Partners in Recovery (PIR): Coordinated Support and Flexible Funding for People with Severe and Persistent Mental Illness with Complex Needs. The new program is part of the Australian Government’s $2.2 billion mental health reform package. It represents a flexible new approach to helping the target group, people with complex needs as a result of persisting mental health issues, and has been designed after extensive consultation with consumers, carers, clinicians and non-government organisations.

Around 60,000 Australians have enduring symptoms of mental illness and complex multi-agency needs. PIR will focus on around 24,000 of these (most of whom are in their mid-20s or older), their families and carers. In our consultations we heard that these individuals in particular have persistent symptoms which prevent them functioning within the community. Many are disconnected from social or family support networks and rely on multiple health and community services to help them to live outside institutional care.

They may also have drug or alcohol issues or physical health issues, and often find it hard to maintain stable accommodation or to get through daily living. They require more intensive support to effectively address the complexity of their needs than is currently available.

The Australian Government’s Mental Health Reform Package will provide the most significant investment in mental health services in Australia’s history with new programs such as headspace, online services like the new e-mental health portal and a major expansion of access to allied psychological services. It also brings state governments to the table with a $200 million National Partnership Agreement to improve the response of state government health and housing services to the needs of people with mental illness.
Despite this new investment, people accessing mental health services, their families and carers have provided consistent feedback to our Government that current care for people with complex needs is not adequately coordinated. As a result these people often fall through service gaps and miss out on some of the services they need.

PIR addresses this problem by providing a link between the multiple sectors, services and supports and enabling them to work together. It will not offer a new ‘service’ in the traditional sense, but rather its aim is to bind together the available services – to build true collaborative partnerships between existing services across a range of sectors tailored to the needs of the individual client. To put it simply, PIR aims to ‘wrap’ care around the individual who needs it.

The program is unique because it will provide one point of contact for people in the target group, as well as their families and carers, and will coordinate the full range of available assistance. The burden will be lifted from clients and families who currently find it confusing and time-consuming to navigate the wide range of government and non-government services on their own. It is hard for any one of us to traipse all around town looking for Centrelink, then the housing office, then the Medicare office and then our doctor and pharmacist. But that challenge is exponentially harder for those suffering from severe mental illnesses such as psychosis or acute depression.

PIR will improve the way that our health and social support systems respond to people with severe and persistent mental illnesses in a number of ways. PIR will bind together supports and services through:

- building partnerships and better communication links between a wide range of clinical and community support organisations,
- promoting a common goal of community based recovery amongst the clinical and community support services engaging with the individual,
- driving collective responsibility for clients and encouraging innovative solutions to ensure effective and timely access to services and supports,
- better coordination of the clinical and other supports and services to deliver wrap around care individually tailored to the person’s needs, and
- improving referral pathways to the range of services and supports needed by the PIR target group.

The key principles of the implementation of PIR are that it will be recovery oriented and client focused, flexible in its roll out, and complementary to existing service systems.
It is very likely that the improved collaboration between care and support services and sectors fostered through PIR will have positive flow-on impacts for a broad range of people, including people with mental illness who are not in the PIR target group.

There will be one PIR organisation in each of the 61 Medicare Local geographic regions. The PIR organisation will be a non-governmental organisation (NGO) and we hope to see consortia of organisations coming together to collaborate in each region.

To be chosen, PIR organisations will need to show that their staff can build partnerships and collaborate between multiple services and sectors relevant to the needs of clients.

These needs may include specialist mental health services, public housing, education and employment services, domestic violence and justice services, private psychiatrists and psychologists, GPs, allied health professionals, hospitals, specialists, alcohol and other drug treatment services, disability support services, and those who can provide income support.

PIR organisations will also engage appropriately skilled and experienced people as Support Facilitators. The Support Facilitators will undertake the day to day PIR work as the ‘point of engagement’ for clients. They will receive and review referrals, assess client needs, develop and monitor PIR Action Plans, and engage with existing case managers, services and supports to ensure that client needs are met to the best possible extent.

PIR operations will vary from one region to the next according to the needs of the target group and the existing, local service delivery systems. The PIR approach will give services across different sectors collective ownership and shared responsibility for meeting client needs.

Broad consultation has been undertaken on the design of PIR. The Government has been working closely with key stakeholders, experts, consumers and carers to fine tune the Program Guidelines for PIR organisations.

An Expert Reference Group was established in December 2011 and workshops for stakeholders were held by the Mental Health Council of Australia and the Australian General Practice Network last year. Discussions between DoHA and all states and territories are also ongoing.

The engagement of PIR organisations is expected to start in early 2013. Successful organisations will initially focus on building their organisational and workforce capacity and expertise so they are ready to start seeing clients after an establishment period.

Eligible organisations can view the Program Guidelines, application guidance and other information at www.health.gov.au/mentalhealth. Applications for funding to become a PIR organisation and implement PIR close on 18 December 2012.

The release of the program guidelines in August this year should give organisations time to build and plan partnerships within their region.

Sectors, services and supports are strongly encouraged to get together within their regions to jointly determine local needs and identify existing services and sectors (and any gaps) on which to build PIR. They should also discuss a suitable PIR model, which organisation should be the PIR provider and who its PIR partners should be.

Information sessions for PIR stakeholders were held in each capital city and Cairns in August and September 2012. These sessions provided a face-to-face opportunity to share information about PIR and the application process, as well as respond to questions. The Sydney information session was filmed and is now available for viewing on the website below.

PIR is a new and exciting initiative. Getting things working better for this cohort is difficult and complex work, but the Australian Government is determined to help some of the most vulnerable people in our community. For the first time, Australians with severe and persistent mental illness will be given the extra assistance to better connect them with the complex care and support systems they need.

FIND OUT MORE: For more information, please see www.health.gov.au/mentalhealth. Inquiries can also be directed via email to partnersinrecovery@health.gov.au.
Our task is to design our system for the people who need us the most, so you would think that people with co-occurring mental health and substance use conditions, and other complex needs, would clearly be prioritised for system level attention. However, exactly the opposite tends to be the case.

Changing the world! What do we mean by that? For the past 12 years, we (the authors) have worked across the United States, in Canada, and, more recently, in Australia – in Victoria, Queensland, Western Australia, and Tasmania. Our focus has been on helping behavioural health and health systems reorganise on every level to be about the needs, hopes, and dreams of the individuals and families with complex lives who come to them for care. This process is sometimes given fancy names, like “integrated recovery-oriented system transformation”, but its most basic goal is to help complex service bureaucracies with limited resources move to a system where every dollar, every program, every person providing care, and every policy, procedure, and practice is matched to what people actually need and want.

Our goal, therefore, is not to ‘work around’ the system, but rather to challenge it as a whole and to respond to who its ‘customers’ actually are and what they need.

I. Complexity
Let’s think first about the people for whom the system is NOT well-designed. A good example in the behavioural health system are the people and families who have co-occurring mental health and substance-use conditions, sometimes called co-occurring disorders.

What do we mean by people with co-occurring conditions? We mean any person of any age with any combination of any mental health problem (including trauma), and any substance use/addiction problem (including gambling and nicotine), whether or not they have already been diagnosed. We also consider co-occurring families, in which one member might have one kind of problem (like a child with an emotional disturbance), and another member might have another kind of problem (like a substance-use disorder), so that the family system needs an integrated approach.

Why do we start with this group of people? First, almost immediately, everyone comes to the table. In Victoria, people and families with co-occurring conditions are present in the community managed mental health sector, as well as in the alcohol and other drugs (AOD) sector and the clinical mental health sector. Second, many of these people do not only have mental health and substance use issues, but also
medical, housing, legal, parenting, disability, and cognitive issues. They are characterised by complexity. Third, the more complex you are, the worse you are likely to be doing. So these individuals experience the poorest outcomes and generate the highest costs in our scarcely resourced service system. Their poor outcomes are in every area: relapse, rehospitalisation, jail and prison tenure, homelessness, victimisation, disability, poor health, and early death.

Now, here’s the most important point:

If our job is to design our system for the people who need us the most, then you would think that people with co-occurring mental health and substance use conditions, and other complex needs, would clearly be prioritised for system level attention. However, as we know, exactly the opposite tends to be the case. These individuals are experienced as misfits at every level: at the system design level (with three different sectors, none of which is specifically designed for co-occurring people); at program design level; and the level of competency of people delivering care.

When community managed mental health system staff encounter people with co-occurring conditions, they are likely to experience a mismatch between what clients need and what they (the staff) know; and the clients experience this as well: ‘Here’s someone else acting like they’re not sure what to do with me.’ Not only that, we often experience the clients negatively. They don’t fit what we know how to do; they don’t do what we want, and they don’t achieve the outcomes we are hoping for; so they stir up feelings in us, ranging from hopelessness and despair to frustration and rage. At times they are labelled ‘antisocial, manipulative, borderline, med-seeking and sociopathic’. We are programmed so that the people who need us the most are often being held at arm’s length.

For this reason, the first step in redesigning the entire system is to create a system in which the people and families with co-occurring conditions and other complexity are specifically, purposely, and proactively welcomed for care – exactly as they are, wherever and whenever they show up.

2. Prevalence
The next driver for doing this throughout the whole system is that not only are there people with co-occurring conditions doing very poorly, there are lots of them.

The prevalence of co-occurring conditions in every program, in every sector, is so great that we say ‘co-occurring (or complexity) is an expectation, not an exception’.

There is a lot of epidemiologic data in Australia that demonstrates this, but it is most obvious by simply looking at who comes in the door. What is striking is how the whole system, with limited resources, is organised as if this isn’t true. In a system of care that is resource challenged, we keep putting the ‘expected’ people, who have the poorest outcomes and highest costs, in single disorder services, guaranteeing poor outcomes and high costs. All the while we are wishing for new pots of money or special programs or staff, or trying to get everyone with multiple issues to attach to multiple programs and funding streams. This will not work.

If our job is to design our system to be about the people who need us, we need to build the capacity to address the needs and inspire the hopes of people and families with complexity into absolutely everything we do.

The good news is that we actually know how to do this.
**Integrated system of care**

We have developed a model called the Comprehensive Continuous Integrated System of Care (CCISC) (Minkoff and Cline, 2004, 2005). This is a model for system design and a process for getting there. The core elements are as follows:

- Every program in the entire system engages in an organised quality improvement process (within its base resources and current ‘job’ or mission) to become welcoming, hopeful, strength-based, recovery oriented, and complexity (co-occurring) capable. That is, every program becomes a co-occurring program.
- Every person providing service or support engages in a process, within their own job, at their own level of training, to become welcoming, recovery oriented, and complexity (co-occurring) competent as well. This means that every service worker (whether a case manager, overnight residential staff, or peer support worker) is given a set of skills to be helpful and hopeful for the people with complex issues.

This does not mean that every mental health program becomes an addiction program or vice versa; it does not mean that every social worker or case manager becomes an addiction counsellor or vice versa. It means that each program organises all of its policies, procedures, and practices, and all of its staff competencies and instructions, on the assumption that the next person showing up will have multiple issues and will routinely require integrated services to address all of these issues.

This is a big vision. How do we get there?

**Principles of intervention**

The good news is that there is now sufficient clinical and organisational knowledge to help any type of service system implement this big vision. Let’s start with the clinical knowledge. Over the past 20 years there has been a steady accumulation of research on helping people with co-occurring conditions progress toward recovery. During the past decade, there has been further movement away from studying special ‘evidence-based practice programs’ towards identifying successful practices and interventions, and helping any program to implement the practices that work routinely, so they can be delivered by any staff, working in any setting, with any population. This process is known as ‘implementing co-occurring capability’ at the program level.

In the context of this work, consensus practice development materials have emerged that provide instructions to people on the front lines. In 1998, Minkoff chaired a panel for the US Substance Abuse and Mental Health Services Administration developing standards of care, practice guidelines, and workforce competencies for large systems addressing co-occurring disorders. From the Dartmouth group that developed the Integrated Dual Disorder Treatment special program toolkit, Mueser et al (2003) wrote a textbook for unlicensed case managers and rehabilitation workers entitled, “Integrated Treatment for Dual Disorders: a guide to effective treatment”. The US Center for Substance Abuse Treatment produced, in 2005, “Treatment Improvement Protocol 42: substance abuse treatment for persons with co-occurring disorders”, designed for front line substance abuse (and other) practitioners. What we (the authors) have done is distilled this consensus material into a set of simple principles of successful intervention. The principles are summarised below, along with the associated interventions:

**Principle 1: Co-occurring (or complexity) is an expectation.** This expectation must be incorporated in a welcoming manner into every practice and program. It should be associated with the removal of arbitrary access barriers that prevent welcoming, integrated screening so we make it easy for service providers to see, and for clients to share, all the complex issues with which they present. This is basic ‘customer service’ for the most challenging customers: ‘Hi, there. You know you have both mental health symptoms and you are actively using substances. You’re the kind of person we most need to be engaging here, because you are likely to have the hardest time. We know it’s not easy for you to come and ask us for help. Thank you for coming; you’re in the right place. We’re really glad you’re here. We know our job is not to fix you or control you the moment we meet you; our job is to get to know you, inspire you with hope, and help you connect with us to address all your issues, over time, so you can have a happy, successful life!’ The goal is not to just think that it is a nice idea but to implement that message by policy, procedure and routine practice in any setting.

**Principle 2: Empathic, hopeful, integrated, strength-based recovery partnerships are the foundation of success.** We need to build policy and paperwork so routine assessments are based on identifying inspiring goals, empathising with all the complexity in a person’s story, partnering with people in ‘integrated relationships’ to help them with all their issues (including ones that we ourselves are not ‘experts’ in), and focusing always on the strengths that people use to address all their issues during all periods of positive progress, so we can help them to get stronger. (There is no such thing as ‘chronic relapers’; only people like ourselves who are recurrently successful.) Further, people get better in small steps for each issue over an extended period of time. When delivering ‘integrated treatment’ to people with serious mental illnesses and substance use conditions, who are not initially interested in abstaining from use, it will take about
3–4 years for about half that population to achieve a state where they are abstaining from substance use. The other half in meantime by the end of that period make significant progress in their lives, even though they may still be using substances, as they are connected more effectively into hopeful, integrated relationships with their care team.

Principle 3: People with co-occurring conditions are not all the same. We can use the Four Quadrant model to assign system and program responsibility for different populations, while all programs in the system help each other work more effectively with their particular populations. For people with serious mental health conditions who may have both high severity substance-use disorders (Quadrant 4), such as addiction and lower severity substance-use disorders (substance misuse or abuse, which has a lower individual threshold) (Quadrant 2) who are accessing community managed mental health services, that sector’s job is to provide empathic, hopeful, integrated interventions to these individuals as a routine feature of care; the job of the AOD and clinical mental health sector is to provide the consultation, education, partnership, and in-reach to help achieve that goal.

Principle 4: All the co-occurring conditions are primary. All conditions (medical, mental health, substance use, housing, legal, disability, etc.) are important to the people who have them. In response we help them identify the best next step for each issue, one day at a time, and to do so for all their issues at the same time. This is termed ‘integrated, best-practice matched interventions for multiple issues’. The simpler we make it, the easier it is for both ourselves, and our clients to succeed over time. The following two principles help us to match the interventions properly.

Principle 5: Integrated interventions and outcomes must be stage-matched for each issue. Everyone is facing multiple issues in their efforts to be happy; but almost no one is in the same place for all their issues at the same time. We have a language for this: moving through stages of change and an associated, evidence-based approach called stage-matched interventions, which includes motivational interviewing for partnering with people in earlier stages of change. The stages of change can be described as pre-contemplation (‘don’t bug me about this issue’); contemplation (‘I’m willing to talk about this, but I’m not ready to change’); preparation (‘I need help to find a baby step to begin changing’), early action (‘I’m working on some things to change, but I’m not committed to doing everything’), late action (‘I’m trying to get stable, but I need some help to learn more about how to do that’); and maintenance (‘I’m stable and trying to stay that way as life throws challenges at me’). Each stage has interventions and outcomes specific to that stage. For example, if someone is in pre-contemplation for an issue, motivational interventions can be engaged to help them to move into ‘contemplation’. That is, they go from ‘don’t bug me’ to ‘I’m willing to talk.’ Most important, if anyone ever asks you what stage of change a client is in, the correct answer is always: ‘For which problem?’ Stage-of-change is issue-specific, not person-specific.

Consequently, the best approach for integrated care is to provide a stage matched intervention for each primary issue at the same time. Further, if we are to apply this in any program, it would mean that all of our assessments and treatment plans documented stage of change for every client for every issue, so that all the interventions are integrated and stage matched.

Principle 6: Progress occurs through adequately-supported, adequately-rewarded, skill-based learning for each issue. For any issue, when the individual wants to make a change, our job goes beyond making recommendations and writing prescriptions. Our most important job as partners is to teach skills, both in self-management and in asking for help, whether from peers, family members, or service providers. Skill-based learning is the foundation of treatment, and skills have to be taught in small steps (‘adequately supported and structured’) with big rounds of applause for each step of success (‘adequately rewarded with positive contingent reinforcement’). Further, there are increasing numbers of manuals available to help both clients and staff learn the necessary skills: “Seeking safety” (Najavits, 2003) to teach trauma management skills in early sobriety; ‘Overcoming addictions: skills training for people with schizophrenia’ (and other types of mental illnesses) (Roberts et al, 1999).

In the latter, they teach us that the learning is more successful the simpler the skill acquisition is organised. For instance, instructions and role plays around specific topics such as: how to refuse drugs offered by a dealer or telling a counsellor or case manager that you used substances, and so on. Again, we ask ourselves if we are routinely using skill-based learning for each issue, and routinely applauding success in all of our treatment plans and interventions.

Summary of the Principles

Our goal across the whole system, in every program, with every person, and with every dollar, is to welcome people with complexity into empathic, hopeful, integrated, continuing recovery partnerships, in which we provide adequately-rewarded, adequately-supported, strength-based, stage-matched, skill-based, community-based learning so that consumers can make step-by-step progress addressing all their issues to achieve happy, hopeful, and meaningful lives.
Conclusion: Organising the state-wide partnership for change

As well as knowing how to make clinical progress, we also know how to make organisational progress. In a huge system, like the whole state of Victoria, we need to initiate a large systemic ‘quality improvement partnership’ in which each program can take deliberate steps, in the context of its base resources and mission, in the direction of this vision. This change should come through partnership between senior leadership, program managers, and empowered front line staff who become change agents in the quality improvement process. ZiaPartners (Minkoff and Cline) has provided tools for systems, programs, self-assessments (e.g. COMPASS-EZ), and clinical tools (e.g. CODECAT-EZ) to help Victoria make progress. Several Victorians (representing VAADA, NW Hume, Knox Community Services, and other organisations) attended our international Change Agent UnConvention in California last autumn.

The best news is that progress has already been made in Victoria, led by VAADA1. The vision is to create a quality improvement partnership demonstrating how to make state-wide progress in co-occurring capability using base resources (not grant funds). Change agents are welcome from the community managed mental health sector to form an empowered team to overthrow the established order and create, at every level, a system that is better matched to the hopes and dreams of the people who most need our help.

FIND OUT MORE: For more information about international change, please visit
http://connection.ziapartners.com and www.ziapartners.com

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1 Merissa van Setten from VAADA has collaborated with the federal Integrated Services Initiative (ISI) to steer many programs toward co-occurring capability (many using another tool, somewhat similar to the COMPASS-EZ, called the DDCAT). Victoria has also identified a network of change agents around the state, including Gary Croton, who is recognised nationally as a change agent leader. Comprehensive resources are available at Dual Diagnosis – Australia and New Zealand Support: www.dualdiagnosis.org.au
All consumers are equal, but are some more equal than others?

Flick Grey and Merinda Epstein, Our Consumer Place

Everyone deserves to have their experiences and emotional pain accorded respectful attention and care.

The diversity of experiences and diagnoses brought together under the umbrella of ‘mental illnesses’ are grouped and divided in various ways depending on the priorities and interests of services, researchers and bureaucracies. This includes clusters of interlocking, context-sensitive hierarchies. These hierarchies are usually covert, often counter-intuitive and even contradictory, yet they tend to override any considerations of emotional pain or support needs in governing eligibility and priority for services, attention and public sympathy. The political and value-laden nature of these hierarchies is hidden by value-neutral language causing priorities, exclusions and silences to seem justified, even self-evident. In this article, we make these hierarchies overt, so they can be opened up for dialogue.

To expose these hierarchies is not to criticise those who find themselves ranked as ‘deserving’ or ‘legitimate’ according to this logic. Everyone deserves to have their experiences and emotional pain accorded respectful attention and care. Unfortunately, the ways in which attention and care (i.e. services) are distributed and justified – within a finite, strained and defensive system – undermine this basic tenet and have real consequences for those seeking help.

We might believe in the ‘wisdom of the science of psychiatry’ and struggle to see the value judgements and politics hidden behind the veneer of objectivity. If our suffering might be deemed ‘not serious’ or we believe we are ‘seriously broken’, this hierarchical logic can stick and hurt. The situation is only complicated further by the fact that some of us align ourselves within these hierarchies, because it provides some much-needed legitimacy (and/or familiar shame). Some of us are desperate to access services, while others are eager to get services out of our lives, but these hierarchies override our needs and wishes, having real – dare we say serious – consequences.

Hierarchies of ‘prevalence’ and ‘severity’

Terms like ‘serious’, ‘severe and enduring’, ‘complex needs’, ‘high prevalence’ and ‘low prevalence’ are used as if they have ontological validity, when they are really a means to sort out who is entitled to access services (and what kind) and who is not. The terms ‘high prevalence’ and ‘low prevalence’ in the Australian context are products of the influential National Mental Health Strategy studies carried out every ten years. While the target group for the ‘high prevalence’ study is based on a questionnaire directed to random households, the ‘low prevalence’ study is based on people who are already accessing public mental health services, who due to existing service priorities, is mainly people experiencing psychosis. The ‘evidence base’ thus re-inscribes politics.
That is not to say that such terms are meaningless – for example, schizophrenia (the prototypical ‘low prevalence’ diagnosis) is significantly lower in prevalence than depression (the prototypical ‘high prevalence’ diagnosis). However, when ‘low prevalence’ and ‘serious mental illness’ are used as euphemisms for psychosis and when particular kinds of services (or research, or funding) are allocated exclusively on this basis, the logic of prioritisation is not being made explicit. In fact, it mystifies. In the same vein, other diagnoses that are also low in prevalence (perhaps much lower in prevalence!), or whose prevalence is somewhere in between these reified categories of ‘high’ and ‘low’, are rendered invisible and neglected.

**Hierarchies of ‘need’**

Adult mental health service-providers in Australia almost universally judge ‘need’ by diagnosis. In a small, unpublished study by Merinda Epstein (2003), 23 pamphlets describing the work of Area Mental Health Services were collected from services in Melbourne and regional Victoria. They all demonstrated remarkably similar hierarchies of service eligibility: the schizophrenias were invariably on the top of the list followed by other psychotic conditions (including drug induced psychosis), bipolar disorder, ‘serious’ depression or anxiety disorders and then, always last, borderline personality disorder (if a risk to self and others). No other diagnoses were recognised. This may seem a trivial example, but it is experienced as hierarchical.

There are many people who experience debilitating emotional pain and may be desperate for services, but whose diagnoses don’t fit neatly into the logic of service provision. Conversely, people with so-called ‘serious mental illness’ may be involuntarily forced into services that they do not want. This logic is influenced by fear (based on prejudicial ideas about ‘dangerous psychotics’) and pity (based on the image of the ‘poor, hopeless, mad person’). People diagnosed with the schizophrenias and other psychotic illnesses receive a disproportionate amount of this negative discrimination and so there is a tendency to confer the characteristic of ‘need’ upon this group, regardless of the needs articulated by people experiencing psychosis.

**Hierarchies of legitimacy**

Some experiences are granted social compassion and moral exculpation or ‘distress legitimacy’. For example, much work has been done to persuade the public that depression is a ‘legitimate illness’. Though, as one moves down the ‘legitimacy’ hierarchy, people are more likely to be blamed for their own suffering and exhorted to take personal responsibility for their ‘behaviours’. Their experiences are judged, disrespected or dismissed by the community and mental health workers. There are correlates in physical health – for example chronic fatigue, obesity and Type 2 diabetes. This is complicated and sometimes mitigated by social variables such as class, ethnicity, gender and education. For some diagnoses, the distance between social condemnation and diagnosis is slight – for example, anti-social or narcissistic personality disorders, hypochondria or somatoform disorder. Legitimation-through-medicalisation also comes at a price for those for whom ‘medical model’ explanations are a poor fit, or who don’t want ‘medical model’ services.

Hierarchies operate differently in the private system. Private services, of course, are only available to those with the capacity to pay. Some ‘illnesses’, such as eating disorders, are seen more often in the private system. The more compliant, more easily treatable occupy the top of the private pile, along with famous people. Despite being the only place where some of us can receive any service, the private system is not immune to hierarchies based on the medical model, differentiating between those whose pain, thoughts, actions and experiences are defined primarily as biological and those seen as wilful.

**Hierarchies of trauma**

Another form of ‘distress legitimacy’ is associated with a history of traumatic experiences. At the inaugural BPD Awareness day in October 2011, Merinda Epstein spoke about her many years as a consumer activist in the area of BPD. She told of having given three different keynote addresses on BPD, where each time a young person came up to her afterwards and said “I wish I had been sexually abused”. The first time she heard this, she was horrified – at first glance it appeared to be gravely naive or disrespectful. The second time she was intrigued, the third time she ‘got it’. She had learnt an important lesson from these young people about hierarchies of trauma.

These hierarchies had created a legacy of confusion, anger and fear for people labelled with a diagnosis of Borderline Personality Disorder – not deemed ‘a serious mental illness’, a priority for public mental health services, or even a ‘real illness’ – they are relegated to the bottom of the heap when it comes to ‘distress legitimacy’ and access to the appropriate services, caring attention and resources. Shame, distress, emotional pain, fear and hopelessness are judged, dismissed and redefined as ‘bad behaviour’ and people seeking help for this less ‘legitimate’ illness are often refused access to services. Most people have a painful life history hiding behind their ‘mental illness’ (regardless of diagnosis). Many people with a BPD diagnosis say that honesty about their traumatic childhood experiences is useful in their battle against prejudice. However, here we find another damaging, delegitimising hierarchy: a hierarchy of trauma.
Terms like ‘serious’, ‘severe and enduring’, ‘complex needs’, ‘high prevalence’ and ‘low prevalence’ are used as if they have ontological validity, when they are really a means to sort out who is entitled to access services (and what kind) and who is not.

Sexual abuse of children is most definitely heinous. According to the hierarchy of trauma, it is also an ‘acceptably significant’ trauma. That is to say, a great degree of legitimacy may be conferred on one’s suffering if one can name such trauma, particularly when the perpetrator and acts can be clearly identified and named. There is a sense that something awful was done to you and you were blameless because you were a child. Physical abuse is also hierarchically acceptable. Emotional abuse and overt neglect – especially for those who come from poor or visibly ‘dysfunctional’ families – are also considered adequate (consider the expression ‘children at risk’).

Experiences of war, torture and natural disaster are ambivalently included in this hierarchy – as in the mental health context, these frequently go unrecognised. There is also evidence to suggest much higher levels of discrimination from mental health professionals against people with a post-traumatic stress disorder diagnosis. Conversely these socially visible disasters may be recognised as real, significant or legitimate traumas, where the victim/survivor is recognised as blameless and deserving of unconditional support. For example, community and professional responses to the victim/survivors of recent natural disasters, such as the 2009 Black Saturday bushfires or the 2010-11 Queensland floods were quite different to responses to the suffering of victim/survivors of repeated childhood traumas.

Beyond these traumas, there is a gaping silence. Frequently, it is the so-called ‘less serious’ negative experiences that have the greatest impact on people’s mental health: absent, though successful, parents; chaos in everyday childhood life in ‘loving families’; witnessing a sibling being abused; emotional neglect; being sexualised or emotionally manipulated by a parent; invisibility or only being noticed for one’s intellect or sporting prowess; traumas that so readily elicit deep shame but often cannot be named, partly for fear of hurting ‘the innocent’. Trauma that is difficult or impossible to name is often disabling in ways that are invisible to others, and this can be distressing in itself. This promotes theatre: a need to create personal drama stories of the ‘worst kind of abuses’ in order to pique the interest of the media, politicians, funders and services.

So, wishing that one could have experienced sexual abuse as a child can be understood not as a grave act of disrespect, but as a profoundly meaningful response to these complex hierarchies, both as they operate conceptually to make order of the world, and their real-world consequences. These three young people had been told that in the legitimacy hierarchy of illness they were on the bottom and they found that in the trauma hierarchy they were on the bottom once again. Without some kind of socially-recognised trauma history, they were left floundering in shame with nowhere to seek ‘distress legitimacy’, leaving them to feel that their emotional pain is inexplicable, except in terms too easily internalised: they must be bad, over-emotional, unworthy, pathetic, fraudulent, manipulative, difficult, even evil, unlovable, better off dead.

There is potentially another diagnostic hierarchy – rarely spoken out aloud – enwined in this trauma hierarchy. Psychoses and Dissociative Identity Disorder are sometimes assumed to be indicative of ‘worse’ trauma than diagnoses such as Borderline Personality Disorder, Depression, Post-Traumatic Stress Disorder or Obsessive Compulsive Disorder.

What does this all mean?

The experiences, distress and trauma of all consumers, in childhood and adulthood should be taken seriously, not organised into hierarchic structures. While some people can give voice to the trauma in their past, for others it inhabits their bodies silently. It therefore requires sensitivity to support someone to explore their experiences and takes honesty, integrity and care in building trusting relationships. People must be allowed to respect and honour their experiences – whatever they may be – and they might recognise trauma in what seems to others the most unlikely places. Once we recognise this complexity, the language of ‘serious trauma’ (or ‘serious mental illness’) makes no sense.

After giving her speech, Merinda was approached by a young woman, accompanied by her parents, who simply said, “I’m Number Four.”
At a cost of almost $4 million, J2SI is a significant investment and the evaluation will provide clear evidence of whether a targeted intensive approach is more cost effective than leaving long-term homelessness in the hands of the criminal justice, health and crisis service systems.

Journey to Social Inclusion (J2SI) is a Sacred Heart Mission initiated program that aims to demonstrate that a well-resourced and intensive service intervention can break the cycle of long term homelessness.

J2SI delivers intensive case management (1 worker: 4 clients) over a three-year period, a structured therapeutic response to address the underlying trauma that is both a cause and a consequence of homelessness and a ‘Building Up and Developing Skills’ component to equip people with the skills and self-esteem to enable reconnection with the broader community. In addition, J2SI works in close partnership with a range of other services, most notably the Office of Housing (Victorian Department of Human Services) and Alfred Psychiatry, to meet the health, housing and other needs of people in the program.

J2SI began delivering services in November 2009 and is currently supporting 40 people who have been long-term homeless.

Importantly, the J2SI program is being comprehensively evaluated. RMIT University is undertaking a social evaluation and the Melbourne Institute of Applied Economic and Social Research at the University of Melbourne is conducting an economic evaluation. These two universities are working closely to implement a four-year randomised control trial. This means that the 40 clients accessing J2SI services and another 40 people who are eligible for J2SI but are not currently participating in the program (the control group) have participated in surveys every six months for the three-year duration of the program. The surveys track changes in health, housing, social and economic participation over the three-year period and compare outcomes for those who received J2SI services and those who did not. A final survey, to be conducted 12 months after the program finishes, will measure sustainability of outcomes.

This research will also be used to measure the economic impact of the J2SI model. At a cost of almost $4 million, J2SI is a significant investment and the evaluation will provide clear evidence of whether a targeted intensive approach is more cost effective than leaving long-term homelessness in the hands of the criminal justice, health and crisis service systems.

RMIT University is also undertaking a process evaluation to provide a detailed understanding of the systems and processes that underpin delivery of the model and how they impact on client outcomes.
J2SI Participants: Who are we working with?

Data from the initial survey indicate that just over half of the participants are female, most are single (81%), their average age was 36.5 years and all were reliant on Centrelink benefits except one person who is ineligible for government assistance of any kind.

Moving beyond basic demographic data paints a compelling picture of disadvantage and trauma. Just over half report being sexually molested in their childhood (53%), many (38%) have spent time in the State Care and Protection system, over half have been imprisoned (57%) and most have been charged with a criminal offence (87%). A significant majority have slept rough (89%) and they were highly transient with an average of six moves in the six months before the program commenced. An overwhelming majority reported a chronic health condition (93%) and emergency and psychiatric hospital visits were frequent.

How are we going – Progress to date

J2SI is now its final two months of service delivery and, while overall outcomes from the program are positive, there have been successes and challenges throughout the three year program.

Successes

Engagement

J2SI has built and maintained relationships with almost all of the 40 people who commenced with the program in 2009.

Housing

Preliminary data from the 24-month outcomes evaluation indicates that 86% of J2SI participants are in stable long-term housing. Significantly, most of these tenancies have been maintained for over 18 months.

Economic participation

Twelve months into the pilot J2SI established a partnership with Mental Illness Fellowship Victoria, who co-located an employment consultant full-time with the J2SI program. As a result, almost half of participants have engaged in either employment or training. This includes five people who have secured ongoing employment and six people who have completed certificate level courses.

Challenges

Participant drug and alcohol use

Most J2SI participants continue to struggle with substance abuse. This does not mean that work has not been undertaken in this area but demonstrates the challenges associated with changing a lifetime pattern of addiction.

Social Connections

Connection with the mainstream was a clearly articulated goal of the J2SI program. This has proved challenging and many J2SI participants remain engaged with the homeless subculture. The employment outcomes that are being achieved during the final stages of the program provide an opportunity to broaden social and other connections.

As the service delivery phase of the pilot draws to a close it is important that Sacred Heart Mission reflects on and documents what has been learned about service delivery in order to inform policy and program development more broadly.

The Importance of Relationships

J2SI was founded on the belief that the relationship between the participant and the program is the necessary foundation from which change is possible. As such, significant effort was directed towards building and maintaining relationships with participants. As the pilot program draws to a close, J2SI remains connected with almost all of the 40 people who commenced the program in November 2009. This is a significant achievement as people who are long-term homeless are transient, often have enduring mental health issues, and are often caught up in a cycle of substance abuse. Their life experience is one of broken relationships and an understandable resistance to services.

Building these relationships with participants took patience, persistence, creativity, flexibility and resilience. It initially meant finding people at meals programs, health services, or at local rooming houses and consistently demonstrating that we were prepared to hang in for the long haul, listening to people’s stories, and following through with what we said we would do. It also meant adapting our practice to an individual’s journey over a three year period, rather than requiring them to adapt to us. The casework team has maintained contact with participants while they are interstate, in hospital and in prison, or just not being available.

In building and maintaining these relationships, the team also experienced some very challenging behaviour. Crucially, rather than withdrawing the service in response to an incident, J2SI has...
been resourced to understand where this behaviour comes from and work through it. In many instances being able to work through this challenging behaviour is one of the most important things that the program has done. The J2SI participant group expect to be banned from services. In fact they have been banned from services all their life. In not withdrawing the service J2SI has been able to challenge participants’ expectations and move beyond the challenging behaviours. The program has also been able to model respectful and trusting relationships which, over a three-year period, have been a significant and ongoing opportunity for participants to trial new strategies for engaging with the world.

**Service Coordination**

Working with a range of different services necessary to meet the needs of people who are long-term homeless is a well-documented challenge. It has been Sacred Heart Mission’s experience that the resources available to J2SI have made a difference in several ways.

First, J2SI has allowed enough time to facilitate effective collaboration between the multiple services that support individual participants. This work is time consuming and includes keeping all involved services up to date and informed, taking responsibility for convening, hosting and documenting case conferences and, most importantly, working with other services to facilitate a consistent service response. The J2SI team has been working with participants over a sustained period and has been able to develop a detailed understanding of individual needs, issues and behaviours. The casework team has been able to share this knowledge with other services, provide insights about what is going on for the client and what is likely to work in terms of a response.

Second, J2SI has allowed the necessary time to gather the sometimes substantial written material about the individual people that we support. Many J2SI participants have neuropsychiatric reports, files from Disability Services and from Child Protection, Occupational Therapy assessments, and reports from the criminal justice and mental health systems. Gathering this information, identifying and addressing gaps and then trying to make sense of what is often contradictory and out of date information is an important task in building a coherent and detailed story about participants in the program.

Finally, Sacred Heart Mission believes that J2SI has been effective in service coordination because the program sits outside the specialist and clinically based service system. J2SI has a broad focus and has been able to work across the specialist mental health, drug and alcohol, employment, recreation and legal systems to meet individual needs. This has been made possible through training and vital secondary consultation partnership arrangements with specialist providers such as Alfred Psychiatry, ReGen Drug and Alcohol Services and The Lighthouse Foundation. J2SI’s capacity to take responsibility for the full range of presenting issues has been a key factor in successful client outcomes.

**An emphasis on social connections and employment**

A key aim of J2SI was to support participants to re-engage with the mainstream community. While this has proved challenging, Sacred Heart Mission remains committed to the focus on expanding social connections and pursuing employment outcomes.

**Acknowledging and responding to trauma**

Almost all J2SI participants experienced profound trauma in their childhood that has been compounded by a lifetime of disadvantage, poverty and homelessness. The impact of this trauma cannot be overstated and J2SI has demonstrated the importance of a therapeutic, trauma informed service in facilitating positive client outcomes.

**Program accountability**

J2SI is a high profile and expensive program. Sacred Heart Mission and the philanthropic partners that made the pilot possible invested a lot into its development and implementation so closely managing the resources was a high priority. Sacred Heart Mission has established a robust governance framework that includes a Steering Group to monitor overall progress, a Service Delivery Reference Group to provide specialist expertise on practice challenges and an Evaluation Reference Group to oversee the evaluation and address methodological challenges as they arise. As a result J2SI has been subject to a high degree of independent scrutiny and criticism.

J2SI also has three external evaluations that are monitoring progress. These structures mean that every key policy and practice decision made by the program is carefully considered, which leads to a high level of accountability for participants. In short, the program has taken responsibility for participants in a way most services are unable to and this has been another important factor in successful client outcomes.

**Conclusion**

The J2SI pilot has been a rich source of information about how to deliver effective services to people who are long term homeless and have complex needs. Sacred Heart Mission is acutely aware of the importance of documenting and disseminating this information.

FIND OUT MORE: For more information on J2SI and the J2SI evaluation go to www.sacredheartmission.org.
Working with complexity: a map for recovery in forensic psychiatry

Ian Davey, Chief Occupational Therapist, Forensicare
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In an environment such as this where many patients would prefer to be elsewhere in their lives or place of being, the task of providing patients with choice and autonomy within a restrictive environment (where submission can feel like a necessary characteristic of engagement with the service), can prove logistically difficult for all involved.

Introduction

The Victorian Institute for Forensic Mental Health, commonly known as Forensicare, is the key provider and coordinator of adult forensic mental health services in 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 generally caters for three main patient groups:

Security patients: Transferred from prison in need of acute care for their mental health issues.

Forensic patients: Those who 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 Mental Health Act (1986) VIC – are in need of a secure forensic setting to safely manage their mental illness.

During 2010 staff undertook a major review of clinical pathways and the model of care, which led to a number of recommendations. The first recommendation was that a recovery approach to the delivery of services across the organisation be implemented.

This paper aims to highlight the complexity involved in establishing a recovery approach within a highly secure environment where patient choice is historically almost absent due to legal and environmental restrictions and the limitations of a purely clinical approach. The progress achieved so far will be outlined and the culmination of this work reported on and explained. The initial splash of patient involvement was to cause ripples which have exploded into waves reaching across
the entire organisation. Finally, the paper will outline our map for the future direction of the recovery approach at Forensicare.

**Model of care review**

The review of the model of care and clinical pathways at Thomas Embling Hospital commenced in late 2009 under the auspice of Forensicare’s Executive. A Model of Care Steering Committee, chaired by the Acting Clinical Director, met regularly throughout 2010 and directed the review process. The Executive Summary reported that there was a need to update the organisation’s philosophy and approach to care with patient recovery in mind. This single statement provided the impetus and authority for the establishment of a Recovery Working Party which was chaired by one of the participant organisations, Patient Consultants.

“This was a big step forward for our organisation as this was the first time a Patient Consultant had taken a leadership role on such an important committee” VMIAC Patient Workforce Conference (May 2012)

It was imperative that patient knowledge be both extensive and central to laying the foundations of a patient centred care focus. This aligned with a recovery oriented approach to providing services and engaging patients.

To better canvas direct patient experience and feedback a Patient Working Party (PWP) was established to look at and shape various components of care arising from the Model of Care Project (MOCP). Seven patients at various stages of their recovery were drawn from all areas of the hospital as the result of an interview process. A defining aspect of the PWP is that the patients outnumber the staff on the working party. The Forensicare Executive acknowledged the value of the PWP through its dynamic and progressive consulting role. PWP has subsequently been given a mandate to continue running as the Patient Consulting Group (PCG) and is formally incorporated into the organisation’s emerging Clinical Governance structures.

**The complexity of establishing a recovery approach in forensic psychiatry**

Recovery is a word with two meanings.

**Clinical recovery** is an idea that has emerged from the expertise of mental health professionals, and involves eliminating symptoms and restoring social function. In other words, ‘getting back to normal’.

**Personal recovery** is an idea that has emerged from the expertise of people with lived experienced of mental illness, and means something different to clinical recovery. One widely used definition of personal recovery is from Anthony (1993):

‘…a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness’.

Forensicare’s initial definition of recovery was written by two members of staff, but there was an acknowledgement of the need to have patient ownership. The first task of the PWP was to examine and modify the existing definition of recovery. In practice, the group were adamant that they wanted to develop their own definition that took account of their unique perspectives as experienced in a highly secure environment.

The acknowledgement of the offence in the definition took some in-depth negotiation between the patients. Those who had been in the system longer emphasised the significance of dealing with their offence as a key factor in them moving towards recovery. The following definition was finally agreed upon.

“Personal recovery is acknowledging your offence and illness and working through your issues. With this you can gain insight into your mental illness and learn to manage it. Denial is often the first step. Knowing that you need help and asking for it is OK. By becoming involved in your steps to recovery you can build trust and hope. With ongoing responsible action you can lead a meaningful life.” Patient Working Party (2011)

This has now been universally adopted as Forensicare’s official definition of recovery and adorns office walls, noticeboards and the organisation’s intranet homepage.

In an environment such as this where many patients would prefer to be elsewhere in their lives or place of being the task of providing patients with choice and autonomy within a restrictive environment (where submission can feel like a necessary characteristic of engagement with the service), can prove logistically difficult for all involved. However, to their credit the patients have tackled the challenges of the PCG with originality and enthusiasm. Out of their unique approach, the Recovery Pyramid was born.
Seven steps to recovery

Step One: Denial – Paralysis, denial of your situation
Step Two: Despair – Hopelessness, confusion and inaction, giving up
Step Three: Birth of Hope – Initial motivation, a speck of light, optimism
Step Four: Acceptance – Understanding, adaptability
Step Five: Willingness – Eager to move forward
Step Six: Responsible action – Accountability for action, initiate actions
Step Seven: Meaningful life – Ongoing journey with or without symptoms, being a part of contributing in a community.

These seven steps are each related. Identifying where we are on the pyramid will help us identify what our next step could be. It may take time but it is handy to have goals, and knowing what may come next is also very helpful.

Steps are not always in a straight line pathway.

Sources of inspiration

- Maslow’s Hierarchy of Needs
- Deconstructing the Forensicare Recovery definition
- Patricia Deegan’s Recovery. The Lived Experience of Rehabilitation

Figure 1: The Recovery Pyramid

Constructed by the MOCP Patient Working Party from personal experiences

Patients’ Recovery Definition

Personal recovery is acknowledging your offence and illness and working through your issues. With this you can gain insight into your mental illness and learn to manage it. Denial is often the first step. Knowing that you need help and asking for help is OK. By becoming involved in your steps to recovery you can build trust and hope.

With ongoing responsible action you can lead a meaningful life.

Forensicare Commitment to Recovery – Orientated Practice

Forensicare is committed to providing a recovery-orientated health care delivery environment in which the principles of hope, social inclusion, personalised care and self-management are fundamental to practice.

Forensicare recognises that recovery is an individual’s journey towards living a meaningful and satisfying life and that the responsibility of the organisation is to support, and not hinder, that process.
The Recovery Pyramid was inspired by the patients’ re-interpretation of Maslow’s (1970) Hierarchy of Needs. Combining this with their interpretation of the Deegan (1988) article and a process of personal identification of stages of recovery which fitted practically into their journeys, the Recovery Pyramid evolved.

Despite a number of unforeseen hurdles elsewhere in the service, the PCG has continued to break new ground. Various members of the PCG have promoted the Recovery Pyramid at a variety of national and internationally attended conferences this year.

Having the privilege to share this work with a wider audience has resulted in more than just service acknowledgement. The Recovery Pyramid has been shared with services in Western Australia, the Northern Territory as well as the UK. For members of the PCG, this has been a validating experience both individually and collectively. There is a genuine sense of pride and achievement evident when hearing the positive feedback regarding their work. This is captured in the following quote:

“As a natural progression from running groups to presenting at collaborative forums, running workshops and even being fortunate enough to present at conferences, I feel I have blossomed”. Patient D, 2012

**Future direction: meeting the challenges**

The next major challenge for the Patient Consulting Group and wider service is to educate in excess of 300 staff and 100 patients in the principles of recovery orientated practice. The major challenge will be to apply those principles in a meaningful way. To this end the patient consulting group will continue to play a pivotal role in ‘keeping it real’.

Currently the PCG is working with “Jack” – a fictitious case study which illustrates a patient’s journey towards recovery through the Forensicare system and beyond. By using the Recovery Pyramid the patients have shared some of their personal experiences to demonstrate, on a more human level the journey towards recovery. The target audience moves beyond that of their immediate selves – rather it will form the basis of a teaching module to be delivered jointly by members of the PCG, staff from the Recovery Committee and Nurse Unit Managers from the organisation.

Patient B noted;

“With Jack our made up patient for the Recovery Education Package – he is a good role model for outsiders to look at”.

The sessions will be delivered jointly to staff and patients in an organisational commitment to collaboration which encapsulates a true recovery spirit.

**Acknowledgements**

We would like to acknowledge the tireless work and inspiration of all the patients who have been involved in this exciting project. We would also like to recognise the belief that the Forensicare Executive Team has shown in supporting this undertaking.

►►► FIND OUT MORE: For further information about Forensicare, please contact
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**References**


The NDIS: what just happened and where to next?

James O’Brien, Acting State Manager for National Disability Services in Victoria, Every Australian Counts

Clearly, careful thought needs to go into the design of the NDIS to ensure that supports provided to people with psycho-social disability are effective and that the NDIS interfaces effectively with mental health services.

Now the dust has settled after recent political wrangling over the launch sites of the National Disability Insurance Scheme (NDIS), it is timely to take stock and assess what just happened and where to next for the NDIS.

In the lead up to the Council of Australian Governments (COAG) meeting in July 2012, the Every Australian Counts campaign received more than 7,000 messages from Australians telling COAG to lock in the NDIS. This was just one of those received:

“My name is Hayden and I recently received a letter rejecting my funding application for overnight carers so I can continue living in my own home. The letter stated 400 people applied but only 50 were successful. I’m only 34 but because of this I’m now looking at life in a nursing home. Please get the NDIS happening and help me keep my independence.”

The outcomes at the COAG meeting were mixed. Agreements to host the NDIS launch from 2013 were reached with Tasmania, South Australia and the Australian Capital Territory (ACT). However, COAG was yet to make a deal with New South Wales or Victoria, which had lodged a joint bid to launch the NDIS in the Hunter Valley and Geelong regions. The fallout from this action saw a blame game ensue, an impasse with no obvious sign of resolution distressing many people with disabilities, their families and carers, in those prospective launch sites.

The failure of COAG to reach a broad agreement triggered a spirited couple of days of campaigning from supporters and a huge amount of media coverage. Can anyone remember a time when disability had so dominated the public agenda? Even Sky News was running a ‘Disability Update’ as developments unfolded.

The campaigning proved successful and, a few days later, we were pleased to see compromises that would allow launches to go ahead in the Hunter and Barwon regions, although the latter – despite broad ‘in principle’ support –, was subject to another fortnight of tough and tense negotiations before an agreement was finalised.

So, after all the politics, the NDIS will be launched on 1 July 2013 in the Hunter and Barwon regions, and in the ACT as well as two ‘cohort’ based launches; for children aged 0-14 in South Australia and for adolescents in Tasmania.
In the Barwon launch, about 5,000 people with significant disabilities will have their needs assessed and begin to receive individual care and support packages under an NDIS model. According to the Victorian and Australian Governments, this means that people with a disability who are living in the Barwon region will:

- be assessed to receive NDIS individualised care and support packages,
- have decision-making power about their care and support, including choice of service provider,
- be assisted by local coordinators to help manage and deliver their support, and
- be able to access a system that is easy to navigate and that will link them to clinical and community services.

This work will include developing a consistent approach to assessing people’s needs and working with local disability service providers to build the capacity of the disability care workforce.

Under this deal, the Victorian Government will invest over $300 million for disability services, whilst the Australian Government will invest more than $190 million towards individual support packages as well as fully funding the provision of services, local area co-ordination, assessment, service sector capacity building and for the NDIS Launch Transition Agency, operations and administration.

Western Australia is a work in progress but with compromise and good faith negotiations the NDIS will also go west. There are, however, major challenges ahead to convince the Queensland Government to commit to a NDIS launch rather than see it fall further behind the pack.

So despite good progress with deals on five launch sites, the NDIS remains at a critical juncture and the biggest battles still lie ahead. To build on current momentum, the Australian Government must now move to legislate for the NDIS, set up the independent authority to run the NDIS and outline how it intends to fund the NDIS beyond the launch sites. It would be tragic if the NDIS never reached beyond the 20,000 or so people with disability who happen to live within the five launch sites. We cannot have any more lotteries and condemn the nation to the mistakes of the past.

The Productivity Commission (whose 2011 report led to the NDIS) recommended that 410,000 people living with disability should receive direct support under the NDIS. Of those, the Commission estimates about 50,000 people with a psycho-social disability should be eligible for support under the NDIS.

Clearly, careful thought needs to go into the design of the NDIS to ensure that supports provided to people with psycho-social disability are effective and that the NDIS interfaces effectively with mental health services. There is a lot of work now taking place on the design of the NDIS – people should make their views heard on issues like eligibility criteria for direct support via www.yoursay.ndis.gov.au. So, what about funding for the NDIS in the long term?

The Productivity Commission recommended the NDIS be principally funded as a core responsibility by the Commonwealth Government from general revenue. To provide some context, in 2012-13 total federal expenditure is around $370 billion; the extra funding required for the NDIS is $8 billion.

Funding for the scheme will inevitably generate a high level of public and political discourse which could threaten the whole reform. Bipartisanship, on this front, will help.

The extra $8 billion required to fund the NDIS should not be seen as a cost but an investment. The Commission said the NDIS easily passes a cost benefit analysis and, along with other reforms, would boost gross domestic product (GDP) by $32 billion by the year 2050. Without the NDIS, accountants PricewaterhouseCoopers said the amount of money required to fund disability in Australia by preserving our current fragmented, crisis driven approach will reach $45 billion per year by 2035 – well beyond the $8 billion extra required for the NDIS.

In simple terms, the nation cannot afford to not have the NDIS. The process is underway, but if the initial contest to get the five launch sites up and running across Australia is any indicator, our greatest challenges lie ahead.

FIND OUT MORE: For more information about the NDIS campaign or to sign up as a supporter, visit www.everyaustraliancounts.com.au.
Working with complexity: Towards a consumer centered approach

Demos Krouskos, Director, Centre for Culture Ethnicity and Health, CEO, North Richmond Community Health

Complexity is more than dealing with multiple ‘health issues’. Complexity is about the interaction of interwoven social and individual factors such as gender, language, ethnicity, values, identity and the impact of the migration experience on our lives.

Recently a senior counsellor at our service informed me that she had received a letter from a client to thank her for the assistance she had received with a particularly complex matter. This client had arrived in Australia with her family as a refugee approximately five years ago. During that time the client had faced numerous issues in her life which had a major impact on her health and the health of her family. These issues were largely the effects of trauma experienced as a result of war in her home country, dislocation and displacement and living in a refugee camp for many years. Although she acknowledged that her life had improved somewhat since her arrival in Australia there were many unresolved issues that had a continued effect on her capacity to resettle successfully. She struggled to learn English, struggled to find work, there were marital problems and she experienced severe anxiety about the future of her family, especially her children.

The issues described by this client are unfortunately all too common and, reading her letter, it struck me that in my 20 years of working in this community I had heard this story countless times. Many of our clients live with unresolved and untreated health issues particularly anxiety and depression. So what should we do about these issues? As a generalist primary health care service, what meaningful support could we offer this client and other clients with, to use a current euphemism, ‘complex needs’? Our default response for dealing with complexity is case management. However, I will argue that while case management is a necessary component of a comprehensive response to complexity, alone it may not be a sufficient or optimal response. I will also argue that we need to develop a more nuanced approach to dealing with complexity that goes beyond generic case management and is capable of responding to individual needs in a meaningful way.

Let me begin by defining complexity for the purposes of this article. Complexity is more than dealing with multiple ‘health issues’. Complexity is about the interaction of interwoven social and individual factors such as gender, language, ethnicity, values, identity and the impact of the migration experience on our lives. All of these issues are the fundamental drivers of why people seek help and guide us, as service providers, in developing more meaningful and appropriate service responses, as both individual health practitioners and organisations. I will also propose that responding to complexity requires not only innovation of our service models but also of our planning and evaluation models to introduce new perspectives and new knowledge. Fundamentally it requires the development of a consumer focused approach that values the consumer experience as paramount.
Our current service system is largely discipline based and disease or ‘condition’ specific. Healthcare workers are mostly trained in technical skills and how to apply them to specific contexts and respond to specific categories of clinical practice, but healthcare is fundamentally about relationships and communication. Funders allocate resources largely through program structures with well-defined eligibility rules (hence the term ‘falling through the cracks’, which describes clients who cannot access services because the service is not considered appropriate for their needs), and accountability and reporting requirements. Similarly the allocation of health care resources is underpinned by this paradigm which may inadvertently result in inequitable access to care and is not well suited to addressing challenging and complex individual and community needs.

In recent years there has been growing interest in new models of care underpinned by the twin concepts of ‘cultural competency’ and ‘health literacy’. Both of these ideas are relevant to improving models of care to be able to effectively address complexity. Cultural competency can be defined as:

‘…a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations’ (Cross et al., 1989)

And can also be defined as:

‘...professional continually strives to achieve ability and availability to effectively work within the cultural context of the client’ (Davis, 1997)

Health literacy can be defined as:

‘Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Limited health literacy affects people of all ages, races, incomes, and education levels, but the impact of limited health literacy disproportionately affects lower socioeconomic and minority groups. It affects people’s ability to search for and use health information, adopt healthy behaviors, and act on important public health alerts. Limited health literacy is also associated with worse health outcomes and higher costs.’ (U.S. Department of Health and Human Services, 2010)

Consumer focused health care can be defined as the capacity and willingness of service providers to support the direct participation of consumers and carers in all aspects of their care.

So how can we marry these concepts and harness them to improve our current approaches to managing complexity? Can we also identify what the benefit is of this approach and how and where the benefits would accrue?

Improving cultural competency allows us to understand complex contextual issues that have a great bearing on the outcome of any health interaction. A deeper insight into values and behaviours allows us to modify healthcare paradigms to address individual needs. This approach moves away from the previous model of employing flawed cultural generalisations and towards understanding health behaviours and beliefs within the lived experience of individuals, their personal circumstances, their life experience, and all other aspects of their identity. Cultural competency also implies developing cultural respect. Respectful relationships and approaches are key to providing non-judgemental services that value consumers’ experiences and contribute to capacity building and self-management.

Health literacy is normally understood as applying mostly to consumers. There is an assumption that by improving consumer knowledge and skills then they are more likely to make better informed lifestyle choices and choices about their health care. However, this term can also be applied to providers. We can all improve our ‘health literacy’ by improving our understanding of health consumer issues. This will provide a richer and more meaningful context for dealing with complexity.

Ultimately, we need to develop diversity in health paradigms that can incorporate these various insights and knowledge into more dynamic health planning and service delivery. These concepts are still in their infancy, but, with more sustained research into their value and the learnings to be gained from applying them to real life contexts, they have the capacity to innovate and transform our current approach to the planning and delivery of health.

The benefits of a ‘diversity in health’ model accrue both to health services and consumers. For health service providers the benefit is the provision of more effective health care interventions that take account of the reality of a multicultural Australia. The greatest benefit is to consumers because they develop greater confidence in our health care institutions that respect their cultural identity and values and also strengthens their confidence that the services they receive can address their individual cultural needs and aspirations.

**Bibliography**


‘You can’t pull yourself up by the bootstraps if you have no boots’:

The vital role of resources and assets in shaping the development of young people with multiple and complex needs.

Andrew Bruun, Director; Youth Support and Advocacy Service (YSAS)
Penny Mitchell, MPH, PhD, Senior Research Fellow, Youth Support and Advocacy Service (YSAS)

The meaning young people derive from their experiences is expressed in their sense of security, purpose, belonging and hope; all of which profoundly influence their motivation to invest in self-care and constructive development.

In times long gone, a person who, through hard work and perseverance, was able to overcome great hardship was considered to have ‘pulled themselves up by the bootstraps’. Bernie Geary, now Victoria’s Child Safety Commissioner, once explained to an audience of Rotarians that to pull yourself up by the bootstraps you first need boots. More than two decades have passed since Bernie made that address and while modern readers may not even know what bootstraps are, the sentiment expressed through this aphorism is clear and as true today as it ever was. It reminds us that having ‘multiple and complex needs’ is not in itself a problem, but not having access to the resources and assets required to address these needs effectively certainly is.

This article draws on theory and evidence generated from resilience research and developmental science to identify the resources and assets that all young people require to develop in a relatively safe, healthy and constructive way. We intend to demonstrate that where these resources and assets are made available in culturally meaningful ways young people in complex life circumstances and those involved in their care can be enabled to deal with a range of health and/or behavioural problems more effectively. This includes both mental health and alcohol and other drug (AOD) related problems.
**What do we mean by resilience?**

Resilience at its most basic describes a person’s capacity to face, overcome and even be strengthened by life’s adversities.

Early resilience research tended to focus on the qualities of the individual, and those who did well despite multiple risks were described as invulnerable (Anthony, 1974) or invincible (Werner and Smith, 1982). These terms proved to be misleading, implying that a child or young person’s capacity to evade or cope with risk was absolute and unchanging. As research evolved, it became clear that the processes shaping one’s capacity for resilience are dynamic and occur under specific circumstances (Masten, 2001). Howard and Johnston (2007) emphasise the importance of context and demonstrate that, given favourable conditions, young people can develop resilience and reduce or eliminate the need to adopt behavioural coping responses that are destructive and health comprising. Even so, we temper this note of optimism by acknowledging that in rare circumstances “…levels of risk and adversity are so overwhelming that recovery is extraordinarily rare or impossible.” (Masten & Obradovi, 2006, p21).

All resilience research shares the basic assumption that there are potentially many factors that can contribute to how people deal with adversity and life stressors. Risk factors are defined as those that predispose a young person to poor social and behavioural outcomes (Williams et al., 2009; Lerner and Benson, 2003; Bond et al, 2000). Conversely, protective factors reduce the likelihood of this occurring and moderate the influence of other risk factors.

Numerous studies show striking consistency in defining a set of fundamental factors that determine the capacity of children and young people to demonstrate resilience. Masten (2009) draws from this extensive and diverse evidence base to identify a short list of such factors. They are:

- Effective parents and caregivers
- Connections to other competent and caring adults
- Problem-solving skills
- Self-regulation skills
- Positive beliefs about the self
- Beliefs that life has meaning
- Spirituality, faith and religious affiliations
- Socioeconomic advantages
- Pro-social, competent peers and friends
- Effective teachers and schools
- Safe and effective communities

Masten also highlights fundamental protective systems that nurture human development and resilience. These systems generate processes that can produce and sustain the above protective factors: They are:

- The human attachment system (beginning with primary care givers and expanding with development to include families, peers and significant others)
- The human intelligence and information processing system (a human brain in good working order)
- The mastery / motivation system (motivation to adapt and opportunities for agency)
- The self-regulation system (self-control and emotion regulation)
- Religious and cultural systems
- School and community based systems

Like people, these systems are not invulnerable and require nurturing. “The greatest threats to young people occur when these key systems and the capacity they represent are damaged or destroyed and never restored.” (ibid p32). Masten (2001) points out that it is most often the children and young people who contend with the greatest adversities that do not have the protections afforded by access to adequate resources and social ‘scaffolding’ capable of regulating their exposure to risk.

**Complexity and vulnerability**

All young people are vulnerable to disruptions and challenges during the transition from childhood to adulthood. For the majority such vulnerability “…is managed through family, recreational, social and cultural support.” (DHS, 2008; p12) Fleming & Ledogar (2008) stress that when a young person is adequately supported and resourced, exposure to threats or challenges can be an opportunity for learning and personal growth.

While developmental problems can arise for young people who are not exposed to enough risk and adversity, the emergence of health and behavioural problems is strongly associated with the accumulation of risks and adverse experiences, particularly in a concentrated time window (Masten & Obradovi, 2006). Adversity seems to be most debilitating when it comes in multiple forms. Gilligan (2008) adds that “…young people may be able to cope with one or two fairly serious adversities in their lives, but as the number of adversities rise to three, four or beyond, they may begin to buckle under the strain” (ibid, p38).
Figure 1: Framework for Resilience Based Intervention

<table>
<thead>
<tr>
<th>Resources &amp; Assets</th>
</tr>
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<tbody>
<tr>
<td><strong>External</strong></td>
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<tr>
<td><strong>Social Ecology</strong></td>
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<tr>
<td>Material resources &amp; assets</td>
</tr>
<tr>
<td>Degree to which young person (&amp; / or their carer/s) has access to:</td>
</tr>
<tr>
<td>• Income</td>
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<tr>
<td>• Housing</td>
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<td>• Food &amp; clothing</td>
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<td>• Information technology</td>
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<td>• Transportation</td>
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<td>• Safe physical environments</td>
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### Domains of Need

- **Protection from harm & capacity to respond to crisis**
- **Stability & capacity to meet basic needs**
- **Participation in constructive activity**
- **Developmentally conducive connections**
- **Greater control of health compromising issues / behaviours**
## Resources & Assets

### Internal

#### Knowledge / Skills & Attributes
- **Ability (I can)**

<table>
<thead>
<tr>
<th>Living skills</th>
<th>Self-management Skills</th>
<th>Interpersonal skills</th>
<th>Attributes</th>
<th>Self-concept &amp; world view</th>
<th>Meaning making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health literacy</td>
<td>• Insight (self awareness)</td>
<td>• Insight (social awareness)</td>
<td>• Temperament</td>
<td>• Self esteem</td>
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<tr>
<td>Self care knowledge</td>
<td>• Regulation of emotion &amp; arousal</td>
<td>• Communication skills</td>
<td>• Concentration &amp; attention</td>
<td>• Self efficacy</td>
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</tr>
<tr>
<td>Self-care skills</td>
<td>• Problem solving &amp; decision making skills</td>
<td>• Assertiveness skills</td>
<td>• Intelligence</td>
<td>• Gender identity &amp; sexuality</td>
<td></td>
</tr>
<tr>
<td>(budgeting, cooking, etc)</td>
<td>• Ability to make sense of experiences &amp; put them into context</td>
<td>• Ability to find a balance between personal needs &amp; the needs of others</td>
<td>• Physical talents &amp; abilities</td>
<td>• Values &amp; attitudes</td>
<td></td>
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<tr>
<td>Resourcefulness</td>
<td></td>
<td></td>
<td>• Fitness &amp; health</td>
<td>• Interests &amp; commitments</td>
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<tr>
<td>(ability to access &amp; utilise resources)</td>
<td></td>
<td></td>
<td>• Appearance</td>
<td>• Core cognitive schemas (re self / world)</td>
<td></td>
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<tr>
<td>Numeracy</td>
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<td>• Mood &amp; affect</td>
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<tr>
<td>&amp; literacy</td>
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#### Beliefs
- **Identity (I am) & Motivation (I will)**

|                         |                          |                      |                      | • Sense of security (coherence) |
|                         |                          |                      |                      | • Sense of purpose           |
|                         |                          |                      |                      | • Sense of belonging & connectedness (feeling connection to something greater than oneself) |
|                         |                          |                      |                      | • Hope & expectancy         |

### Living skills
- Health literacy
- Self care knowledge
- Self-care skills (budgeting, cooking, etc)
- Resourcefulness (ability to access & utilise resources)
- Numeracy & literacy

### Self-management Skills
- Insight (self awareness)
- Regulation of emotion & arousal
- Problem solving & decision making skills
- Ability to make sense of experiences & put them into context

### Interpersonal skills
- Insight (social awareness)
- Communication skills
- Assertiveness skills
- Ability to find a balance between personal needs & the needs of others

### Attributes
- Temperament
- Concentration & attention
- Intelligence
- Physical talents & abilities
- Fitness & health
- Appearance

### Self-concept & world view
- Self esteem
- Self efficacy
- Gender identity & sexuality
- Values & attitudes
- Interests & commitments
- Core cognitive schemas (re self / world)
- Mood & affect
Young people considered to have ‘multiple and complex needs’ are often experiencing adversity in numerous spheres of life. From the perspective of a practitioner endeavouring to formulate an effective response there are considerations that go beyond the number of adversities or problems in determining the level of complexity experienced by young people including:

- The severity of each problem (degree of adversity);
- The extent to which particular problems are either highly advanced or in an early stage of development; and
- Whether problems cluster together to intensify the risk of harm or reinforce each other to form long-term, negative chain effects, which can entrench health and behavioural problems.

Complexity however does not determine the young person’s level of vulnerability. This requires investigation of the young person’s developmental stage and an analysis of the nature and quality of the resources and assets that can be mobilised to deal effectively with the adversities he or she has to contend with.

**Resources and assets**

The short list of protective factors and systems identified by Masten (see above) are resources and assets found either within the individual or their environment.

Within their framework for resilience based intervention (Figure 1) Bruun & Mitchell (2012) articulate 3 categories of resources and assets that young people require to demonstrate resilience in response to difficult and complex life circumstances. Their first category pertains to the external or contextual resources and assets available within a young person’s social ecology. The second and third categories, ‘Knowledge, skills and attributes’ and ‘Beliefs’, both pertain to internal resources and assets that are qualities of the individual.

**Social ecology: external resources and assets (Figure 1)**

The significance of particular resources and assets located within each young person’s social ecology varies with developmental stage and circumstance. Furthermore, the availability and quality of these resources can vary widely. Poverty, disadvantage and social exclusion all have a pervasive influence on young people’s access to vital material and human resources as well as opportunities for social and economic participation.

**Knowledge, skills and attributes: internal resources and assets (see Figure 1)**

All young people are striving to become socially competent individuals who have the skills to cope successfully with life (Balk, 1995). The Australian Institute of Health and Welfare (2009) identifies a range of skills that support healthy development and correspond with the findings of Bruun and Mitchell (2012), including “…the ability to identify and understand one’s feelings, accurately read and comprehend emotional states in others, manage strong emotions and their expression, regulate one’s behaviour, experience and express empathy for others, and establish and sustain relationships” (p60).

The knowledge, skills and attributes of young people (and of those who support them) influence their ability to locate necessary contextual resources and assets, and to negotiate for them to be provided in meaningful and culturally appropriate ways (Ungar, 2011).

**Systems of belief: internal resources and assets (see Figure 1)**

Young people’s values, interests and beliefs influence how they interpret their experiences, respond to events and approach new opportunities. For example a young woman who believes that she is ‘dumb’ or that she will be victimised by teachers may not seek to re-enter education even when for her it is an important goal. Further, the meaning young people derive from their experiences is expressed in their sense of security, purpose, belonging and hope all of which profoundly influence their motivation to invest in self-care and constructive development.

**Resilience based practice**

In resilience based practice (RBP) practitioners seek to protect and nurture a young person’s capacity to be resilient by altering exposure to risk, influencing the experience of risk, averting chain reactions of negative experience and fostering healthy adaptation and growth (Masten, 2009; Ungar, 2011).

RBP aligns philosophically with the health promotion movement as it is focussed on creating the conditions that enable young people to gain as much control as possible over their own health and wellbeing. This involves young people and those involved in their care having access to resources and assets that make it possible for them to meet their needs, fulfil their aspirations, and respond effectively to environmental influences.

The Youth Support and Advocacy Service (YSAS) has developed a framework for resilience based intervention (Bruun and Mitchell, 2012) that identifies five key domains of need (see Figure 1). They are:

- Protection from harm and the capacity to respond to crisis
- Stability and the capacity to meet basic needs
- Opportunities for participation and constructive activity (education, work, recreation, etc.)
• Developmentally conducive connections (people, culture, places)
• Greater control of health compromising issues and behaviours (e.g. harmful substance use, mental health problems, homelessness, offending, etc.)

A young person's capacity for resilience is strengthened when they have sufficient resources and assets to meet their specific needs within each domain. A lack of appropriate and useful resources and assets to adequately meet these needs can result in both acute and long term problems for young people and families. For this reason, the goals of young people (or those involved in their care) when seeking assistance will typically correspond with any one (or more) of the need domains.

The high incidence of health compromising issues and behaviours present in the lives of vulnerable young people mean that many of them present to services in crisis. Health and community services capable of providing high quality, evidence informed interventions to address one or more of these issues are a vital resource. Even so, the focus also needs to be on safety, protection and stabilisation. Enabling young people to establish and/or protect a secure base can support their efforts to develop more constructive ways to cope with life stressors and underlying issues. A stable and secure base is also a prerequisite for pursuing goals directed at meaningful social and economic participation through which developmentally conducive networks can develop. This promotes social inclusion and a sense of connectedness which are determinants of mental health and well-being (Keleher & Armstrong, 2005).

Masten (2009) explains that well-timed interventions geared to respond at critical moments, have the potential to disrupt negative cascading effects or initiate healthy developmental processes and positive adaptation. Given favourable conditions, even small changes in an individual’s risk profile and functioning can create a ripple effect, possibly generating momentum for further change and development across a range of life domains (Gilligan, 2008; Masten, 2001). Thomson and colleagues (2002) demonstrate that “…critical or fateful moments” (p350) can become turning points for a young person.

Through developing a strong and meaningful connection with a young person, services and practitioners can position themselves to respond at critical moments and with them, mobilise relevant resources and assets in the interests of meeting their needs. The effect might be that chain reactions of negative experience are altered or averted.

Young people with the right mix of opportunity, motivation and resources can move beyond defensive coping into adjustment and positive adaptation.

References


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FIND OUT MORE: For more information visit www.ysas.org.au
The Multiple and Complex Needs Initiative: a coordinated and integrated response

Marilyn Kraner and Verna Fisher, Senior Program Advisers, Victorian Department of Human Services

The objective of MACNI is to provide an effective and coordinated approach to supporting individuals so they can achieve stability in health and wellbeing, housing, social connection and safety, as well as be linked back into comprehensive ongoing support.

Introduction

Mental illness, intellectual disability, homelessness, substance abuse, self-harming behaviour, social isolation, trauma history, personality disorder, acquired brain injury, disengagement, violent behaviour and chronic health issues — each issue, let alone combined with another, left unmanaged can have significant impact on an individual and pose great challenges for the available service system. When multiple issues are experienced by an individual, confusion and chaos can emerge and is often experienced in parallel with the service system. The Multiple and Complex Needs Initiative (MACNI) aims to stabilise this small, diverse group of individuals with multiple and complex needs through an integrated, collaborative and coordinated approach to planning.

MACNI is a time-limited intervention for people sixteen years of age and older who are identified as having multiple and complex needs. This may include combinations of mental illness, substance abuse issues, intellectual impairment, acquired brain injury and forensic issues. Often these individuals pose a risk to themselves and to the community.

The objective of MACNI is to provide an effective and coordinated approach to supporting individuals so they can achieve stability in health and wellbeing, housing, social connection and safety, as well as be linked back into comprehensive ongoing support.

MACNI aims to:

- improve client outcomes for people with complex needs through the provision of a holistic assessment and the development and implementation of integrated care plans
- facilitate the delivery of accommodation, health and welfare services and supports to these clients and
- improve service capacity to work effectively and collaboratively with this client group
The primary tenet of MACNI is that collaborative planning – based on a comprehensive understanding of the individual and their needs – will reduce the crisis driven, reactive responses. The development of an integrated care plan within a person-centred framework typically guides practice and provides a mechanism for continuous reflection and review. Active coordination of such a plan serves to steer the direction of the care plan and ensure that the most appropriate service providers are engaged from across health, welfare and justice. The provision of brokerage funds enables the purchase of additional and more flexible service responses to address the barriers of existing service inclusion criteria and response limitations.

MACNI is a shared service across the Departments of Human Services and Health, in partnership with the Department of Justice. MACNI is directly managed within the Department of Human Services.

This paper outlines the MACNI model and provides commentary on some learnings to date.

**Background**

MACNI commenced in 2004 and was supported by the Human Service (Complex Needs) Act 2003 (Vic) which underpinned the model of support to be provided. In 2009, the 2003 Act was revised and replaced by the Human Services (Complex Needs) Act 2009 (Vic) (the Act). The enduring and guiding principles of the Act require that the wellbeing, health, safety and stable housing of the person are of paramount consideration in decision-making, planning and the delivery of services. The Act also reinforces the view that service planning for individuals is most effective when those services are coordinated, and when service providers share relevant information about the individual being supported. The Act requires that the services are to be delivered in a coordinated manner for a specified period. Importantly, the legislation stipulates that services for individuals with multiple and complex needs should be voluntary, planned and individually-tailored through the development of a care plan.

The introduction of new legislation and accompanying practice guidelines launched a number of changes to the MACNI model in 2009. These included: devolution of some of the decision-making powers of the previous independent statutory panel to a newly established centralised inter-departmental decision-making group, the Central Eligibility and Review Group (CERG), and some other decision-making powers to the Department of Human Services’ regions, an extension of the maximum length of a care plan from 24 months to 36 months, and the replacement of the rigidly linear process for care plan development with a more flexible approach. It was anticipated that these changes would improve the flexibility of the MACNI service response and magnify both individual and systemic issues to those departmental programs with the scope to re-dress service issues.
Who is eligible to receive a MACNI response?

The Human Services (Complex Needs) Act 2009 (Vic) defines the eligibility criteria for MACNI. An eligible person is a person over sixteen years of age with the appearance of two or more of the following criteria:

- has a mental disorder
- has an acquired brain injury
- has an intellectual impairment
- is drug or alcohol dependent

Further to this, the individual must also have exhibited, or be at risk of exhibiting, violent behaviour toward themselves and/or others, and be assessed as deriving benefit from receiving a coordinated response.

The MACNI client

Since 2004 a total of 113 individuals have been considered for MACNI eligibility. A total of 48 individuals received a MACNI service in the 2011-12 year. In addition to those determined eligible, 249 individuals with a range of multiple and complex needs received a regional response through the MACNI process.

To paint a picture of a MACNI client is difficult given the significant diversity in their demographics, life experience, forensic history, health and accommodation status, diagnosis, and service access experiences. The small number overall also means there is significant risk of identification of individuals in the use of case studies. Cumulative data gathered since 2004 to 30 June 2012 provides some generalisable information about MACNI clients.
MACNI regional data reveals that those referred to MACNI:

- 74% are between 16 and 34 years of age
- Majority are men (ratio 2:1)
- 38% present with poor or unstable health
- 40% experience primary or secondary homelessness at the time of referral
- 22% are in custody or prison at the time of referral
- 94% present with the appearance of a mental disorder (MD)
- 40% present with the appearance of a MD and substance abuse issues (SA)
- 36% present with the appearance of a MD and intellectual impairment (II)
- Only 20% have no mental disorder identified at the time of referral, presenting instead with a mix of II, SA and acquired brain injury (ABI)
- 50% of all referrals describe the individual referred as having three of the diagnostic sub-criteria, not just the mandatory two. Of these:
  - 37% present with MD, II and SA
  - 30% present with MD, ABI and SA
  - 20% present with MD, ABI and II

Who can refer to MACNI?

Referrals to MACNI may come from any source including: existing service providers, the individual, family members, guardians or significant others, court support, and correctional services.

In 2011-12, the majority of referrals came from mental health services, including both clinical and community managed mental health services. These referrals made up 34% of all referrals. Following mental health, the most other common sources of referral are disability services (sector and Department of Human Services’ Disability Services) at 19%, justice at 12%, and housing and support services at 5%. Other referrers included child and family services, health services and drug treatment services (Department of Human Services, 2012).

Regional gateway and regional coordination

A referral is currently made through any one of the MACNI regional coordinators located in the department’s eight metropolitan and rural regions.

As the first point of contact for those seeking information about MACNI or wishing to discuss a potential referral the regional coordinator’s role is one of the most important roles within MACNI. Regional coordinators provide preliminary advice about an individual’s likely eligibility and, where appropriate, participate in case discussions and problem-solving meetings to assist in the development of a local response. In the event that local options are insufficient or unavailable, the regional coordinator will facilitate a formal referral to MACNI.

While the process for making a referral is clear, completing a MACNI referral form requires significant worker time and effort. It necessitates the gathering of ‘whole of life’ information that is seldom held by a single service. As such, collaboration with other service providers is often required at this referral point. Such a comprehensive collection of information is not only necessary to assist with eligibility consideration, but also to commence the foundational collaborative planning work of services. In the course of completing a MACNI referral form, service providers have opportunity to reflect on their work and partner with other services in the collation of client information; a process that has positive outcomes for continued service provision stretching well beyond the period of direct engagement with MACNI.

Overview of MACNI referral process and the role of regional panels

Regional panels comprise senior program managers from the Departments of Human Services and Health, independent expert advisers and funded sector representatives from within the region. The panels have authority to approve, review, vary or close MACNI care plans, and to allocate limited brokerage to individual care plans. Regional coordinators support their regional panel with information management and sharing, supporting the implementation of panel decisions and administration, and organisation and network support to ensure effective operations of each panel session.

Improved cross-program coordination and collaboration at the regional gateway level is contributing to a large proportion of matters being resolved locally without the need for referral to MACNI for eligibility determination under the Act. However, where an individual does meet the eligibility criteria and a region concludes that all attempts have been made to find an effective local solution, a request can be made to the Central Eligibility and Review Group by the department’s regional director for determination.
Central Eligibility and Review Group

The Central Eligibility and Review Group (CERG) is comprised of senior program and clinical representatives from the Departments of Human Services, Health and Justice and is chaired by an executive director of DHS. The functions of the CERG include:

- determining client eligibility for MACNI
- reviewing and approving requests for brokerage for individual MACNI clients and
- reviewing care plans on request of a region or other stakeholders for practice advice or support and/or as a quality assurance mechanism

CERG provides opportunities for systemic and strategic reflection and change for an individual MACNI client and broader departmental clients through the participation of senior program and clinical representatives from three departments. To facilitate clinical decision-making and improve transparency and impartiality, both CERG and regional panels make use of independent expert advisers.

Independent expert advisers

Independent expert advisers are individuals with relevant and specific knowledge, expertise or experience in an area relevant to the work of MACNI. This may include expertise in mental health, drug and alcohol abuse, acquired brain injury, forensic issues or disability. Their independence stems from having little or no affiliation with current services that may result in a conflict of interest. Their role in both CERG and regional panels is to contribute ideas and suggest responses to planning dilemmas. They have also been successful in highlighting systemic issues and drawing attention to thematic learnings from the MACNI experience.

What happens if a person is determined eligible for a MACNI response?

Once an individual is determined eligible to receive a MACNI response, a care plan must be developed that is based on a holistic assessment of the individual with a focus on their needs and goals.

Information sharing is necessary to ensure care plans are tailored to a person’s current circumstances and to support the effectiveness of the MACNI service model. As such, an important feature of the Act is the provision of express authority for disclosure of relevant personal and health information by involved service providers (sections 14 and 17). The Act specifically allows a service provider appointed to develop a MACNI care plan to seek information about the client from any person or organisation for the limited purpose of developing a care plan. The Act authorises the department’s Secretary, the Public Advocate, the Mental Health Review Board and any person or organisation providing services to the eligible client to disclose information about this person for the purpose of care plan development.

The Act also allows service providers identified in the care plan to disclose information about a client to another service provider identified in the care plan if it is in the best interests of the client and as it relates to the development, implementation, monitoring and review of a care plan, though the Act does not compel service providers to exchange information. The eligible client has often already had substantial involvement with service providers in the health, housing, welfare and criminal justice systems. Consistent with good practice, authorisation for information exchange within defined parameters facilitates effective care planning.

A snapshot study conducted in 2008 which identified service providers’ views of the impact of MACNI detailed the Act’s information-sharing provisions as a facilitator to the work of MACNI and to the development of collaborative practices between service providers (Department of Human Services, 2008).
Care plan development

Care plans are a pivotal tool and focus for MACNI interventions. The development of a care plan occurs in partnership with the eligible client, their family, carers, partners and the individuals and organisations providing services to the client. Existing assessment information is also collected and analysed in order to enhance understanding of the individual’s needs. As such, assessment is a critical and ongoing element of care planning.

A care plan outlines the plan of action, model of care and type of support recommended for the eligible client by taking into account the client’s best interests. Most care plans identify:

- priority areas of the individual’s life,
- priority goals of the individual
- strategies to engage the individual
- further assessment priorities
- identification of the services and supports and their roles and responsibilities
- a crisis intervention/risk management plan specific to the individual, and
- when and how the care plan will be monitored and reviewed

A care plan is initially established for 12 months. Given the complexity of these matters, many individuals require a longer time period to achieve some level of stability across health, social connection, safety and accommodation. If it is in the best interests of the individual, there is opportunity to extend a care plan for up to a total of 36 months.

Care plan coordination

When a care plan is approved by a regional panel, a care plan coordinator is nominated to work in partnership with the care team and the region to facilitate its coordination and implementation. The establishment of this role has proven to be one of the most critical components of MACNI.

The appointment of a care plan coordinator aims to re-address the crises driven, unplanned and uncoordinated responses to individuals with multiple and complex needs by focusing on improving cross-sector coordination, planning and collaboration (Department of Human Services, 2010). The significance of this role to successful client outcomes is evidenced by a number of evaluations and reviews conducted over several years (Department of Human Services, 2007).

The fundamental functions of the care plan coordination role are to:

- actively steer the direction of the care plan with a future-oriented approach
- skillfully coordinate the care team in accordance with the care plan including negotiating changes to the service provision as required, and
- monitor and provide written and verbal reports to the region on the implementation and progress of the care plan and the client (Department of Human Services, 2010).

A MACNI care plan coordinator can be nominated from either the existing service system when there is local service capacity or MACNI’s statewide care plan development and coordination service, Indigo. Indigo provides a range of assessment, care plan development and coordination, secondary consultation, training, mentoring and co-work functions. Indigo currently develops 99% of the care plans developed for MACNI and coordinates over 50% of all care plans approved.

The ongoing challenges remain working across differing legislative and cultural boundaries, with the most significant being maintaining impetus once MACNI is no longer involved.
Experience has demonstrated that a high degree of skill and effort is required to successfully fulfill the care coordinator role as it is complex and multifaceted. Coordinators use skills of negotiation, mediation, compromise, and influence to steer the care plan forward while managing multiple agencies with conflicting organisational cultures, legislative restrictions, and disagreements arising from differing ideologies, practice principles and risk appetite. Accordingly, the ability to adopt a meta-position is necessary, with the ability to reflect on the client, the care team and the care plan as a whole, varying and maneuvering each component with a future orientation that encourages collaboration and affects positive client outcomes. This is achieved by holding “…a vision beyond the immediacy of necessary ‘client settling’ to include systemic change; requiring a commitment to longer time frames and a systemic focus”, (Hamilton & Elford, 2009).

An evaluation conducted by Indigo (Absler & McDermott, 2009) found that care plan coordination is not the same as or an extension of the case management function, as interpreted at MACNI inception. The primary relationship and the focus of intervention for the care plan coordinator is not with the client but the services engaged with the client. It operates separate to, but in partnership with, case managers and other service providers that form the care team.

As at 30 June 2012, ten local agencies were engaged in providing care plan coordination for 18 MACNI clients. This is the largest number of local services providing care plan coordination in MACNI, in any given year, since its inception.

Client participation in MACNI

Client participation in MACNI is fundamental to this person-centred approach. The Act contains a number of notification provisions that are intended to assist a person to make an informed decision about their participation (see sections 9, 10 & 15 of the Act).

Care plan development and implementation rests upon the engagement of the individual client and their family or significant others. An understanding of an individual’s personal goals, views and ideas are fundamental to the development of a care plan and preferably guide the planning process. Individuals are often invited to participate in care team meetings, attend regional panel review meetings and provide feedback to their case manager or support worker about their needs and views. Where an individual is not in a position to be able to actively participate due to their physical or mental wellbeing, direct service staff are encouraged to attempt to reflect on the individual’s experience.

Refusal to participate

The Act requires the client to be notified of the progress of their care coordination plan at various intervals throughout the MACNI process and that the information is presented ‘in a form that will make it comprehensible to the person’. However, there is no requirement of informed consent. Instead the Act provides for the individual’s right to refuse to participate at any time (section 19). A person may refuse to be considered for eligibility or to have a care plan developed at any time, either in writing or in person.

MACNI under the spotlight – evaluation and reflection

MACNI has been externally evaluated by KPMG (Department of Human Services, 2007) and internally reviewed (Department of Human Services, 2008). Snapshot studies exploring client outcomes have been conducted as well as papers reflecting on the effectiveness of the MACNI approach (Department of Human Services, 2012 (incomplete)).

To date, each review and evaluation acknowledges the uniqueness of this initiative, recognising both strengths and weakness. The snapshot studies provided evidence that MACNI:

- Produces positive client outcomes: The two snapshot studies confirm that for the majority of individuals determined eligible to receive a MACNI response, improvements across all four MACNI platforms of accommodation, health and well-being, social connectedness and safety were evidenced by the service providers working with them at the time of care plan closure.
- Contributes to capacity building of services: feedback from service providers indicates an increased willingness and commitment to working collaboratively and holistically with other providers including the sharing of risk. The majority reported feeling more confident and better equipped to engage with individuals with multiple and complex needs as a result of their experience with MACNI. Improvements in collaboration beyond the MACNI client group was identified as one of the outcomes of being a service provider involved with MACNI.
These studies also identified a number of critical success factors identified by service providers, including:

- coordinated care plans
- care plan coordination
- provision of training and secondary consultation for the care team as part of the care plan
- access to a reflective space, and
- access to brokerage funds that can be used flexibly

The ongoing challenges remain working across differing legislative and cultural boundaries, with the most significant being maintaining impetus once MACNI is no longer involved. In more recent years, the nomination of a coordinator or key leader to continue beyond MACNI has been encouraged as a way of addressing this challenge; however, we are learning that this must be accompanied by regional oversight and some access to flexible funds for continued success.

Conclusion

The Multiple and Complex Needs Initiative enables services and workers to operate in a planned and coordinated way to stabilise a small and diverse group of individuals who have multiple and complex needs. The issues of frustration, isolation and complexity are commonly shared by the individual and the service system if there is a failure to deliver services in this way.

The challenges posed by developing the MACNI service model and engaging others in the approach have been numerous. These include but are not limited to the introduction of a care plan coordination role with authority to support a client’s care team, development of legislation that in its implementation juggles an individual’s autonomy and integrity with the service systems’ powers of information sharing and maintaining the impetus gained during MACNI post the response period.

While MACNI is a time-limited intervention, there is strong evidence that it not only produces positive client outcomes for eligible individuals, but effectively facilitates a collaborative approach to responding to client service delivery with improved individual outcomes for clients.

References


Department of Human Services. (2012). Follow-up review of the impact of the Multiple and Complex Needs Initiative (MACNI) on client progress and the service system: snapshot study, September 2011 – March 2012 - in progress


Victorian Government. Human Services (Complex Needs) Act 2009 (Vic)
Across Australia, the majority of people injured at work return to their jobs within three months of sustaining an injury. By six months 85% have returned to work; whilst after 12 months, a smaller group of just fewer than 10 percent of all injured workers have not returned to work (The Australian Faculty of Occupational and Environmental Medicine, 2011). This latter group is very vulnerable and the majority of them never successfully return to work.

Some individuals in this long-term cohort have ‘catastrophic’ injuries (e.g., severe acquired brain injuries) whereby they require full time ongoing care. But there has also been an increase in individuals progressing into a long-term cohort with chronic non-specific pain and chronic or serious mental illness.

Increasingly WorkSafe Victoria (WorkSafe) and the Transport Accident Commission (TAC) have been championing work on mental wellbeing, with a focus on understanding and addressing recent growth in mental injury claims. Mental health related issues are reflected in two types of claims – primary mental injury (no physical injury) such as post-traumatic stress disorder (PTSD) and stress claims, and secondary mental health issues arising from a physical injury such as anxiety and depression.

The risk of a poorer health and return to work outcome increases with the length of time away from work following an injury. Indeed, it is now widely recognised that there is a link between long periods of time off work and an increasing likelihood of ongoing reliance on long-term compensation or income support. Historically, health professionals have not demonstrated a strong focus on return to work outcomes for their clients, often viewing this as a process that occurs after their treatment has concluded, and to be managed by some other party.

In Australia, requests for general practitioner (GP) sickness certification have increased by 70% in the past nine years (Britt et al., 2006-7, Australian Institute of Health and Welfare, 2008). This has been linked with a significant increase in...
individuals progressing on to disability support pensions (DSP). By mid-2011 Australia reached something of a tipping point where for the first time the number of people relying on DSP was greater than the number of those unemployed (Australian Bureau of Statistics, 2011).

In response, there is an increasing focus by compensation authorities and a range of other government and health professionals to promote the benefits of early return to work. To date, there are two major initiatives that have been developed in Australia to address these issues.

**Health benefits of work**

The first initiative, termed the *Health Benefits of Work Agenda*, was established as a response to a consensus statement released by the Australian Faculty of Occupational and Environmental Medicine (AFOEM) in 2011, which drew attention to the evidence of the benefits of good work on physical and mental health (AFOEM, 2012). The Statement promotes awareness that work is a significant determinant of health to the same degree as genetics and lifestyle factors, and that absenteeism should be minimised as far as medically possible. The Statement now has over 80 organisational signatories. In the past 12 months, WorkSafe has distributed this document to all GPs in Victoria and has been providing education seminars through GP Victoria, conducted by its senior occupational physicians.

The second initiative concerns treatment guidelines for people injured at work or in motor vehicle accidents (MVA). The recently revised *Clinical Framework for the Delivery of Health Services* details best practice principles in treatment for people injured at work or in MVA. The Framework aims to ensure consistency in the quality and outcomes of treatment. It incorporates positive return to work expectations, communication expectations between insurer, employer, health professionals and others involved, as well as a graduated reintroduction to the workplace. It is currently being widely implemented and now serves as the reference point for best practice treatment. Health professionals are being encouraged to align the delivery of their treatment services with the Framework.

In addition to increasing the focus on early return to work, there are further complexities involved in assisting injured workers and those injured in MVA with complex and mental health related problems. Research shows that individuals who do not have a compensable injury tend to show better overall outcomes compared with individuals with the same clinical profile who have a compensation claim (Atlas et al., 2005).

There are a number of factors that have been identified that may variously contribute to these differences in outcomes. These include:

a) Barriers to liaising with multiple stakeholders including different treaters, the insurer, employer and rehabilitation service providers.

b) Financial pressures and uncertainty associated with the necessary time taken to determine whether a claim will be accepted.

c) Psychosocial issues including perceptions of unfair treatment or injustice, a poor working relationship with one’s job supervisor, job dissatisfaction and stress associated with concurrent legal proceedings.

d) Other life stressors including family and relationship problems.

All of these factors can complicate and reduce responsiveness to standard clinical treatment, as well as negatively impact progress on return to health and work.
The compensable system can provide barriers to treatment options and recovery outcomes for injured workers and those injured in a motor vehicle accident due to a range of pressures and uncertainty associated with the necessary time taken to determine whether a claim will be accepted. This is often compounded for those with mental health issues.

Contextual features in relation to mental health issues in compensable settings

The TAC and WorkSafe operate in a mental health provider market that:

- Offers practitioners a range of employment opportunities that are more engaging than those available in the compensable environment.
- In the case of psychologists, is often based on a business and clinical practice model that requires a predictable client flow and/or limited contact over an extended period of treatment and/or exclusively face-to-face contact in specific environments (outreach and more flexible service approaches do not normally form a part of treatment modes).
- Is experiencing workforce shortages, particularly in the area of psychiatry.

To date, the TAC and WorkSafe have:

- Focused provider engagement efforts mostly on psychologists (including neuropsychologists) and psychiatrists in private practice; counsellors, mental health social workers and occupational therapists do not constitute a significant part of the compensable workforce.
- Engaged with practitioners, most often, outside of an interdisciplinary setting.
- Only limited experience in developing sustainable models for engaging public mental health providers in differently funded compensable service provision with the exception of those related to PTSD injuries.

Therefore, the current provider market and ways of engaging with it do not necessarily create an environment in which service access and service coordination are best achieved. This impacts on the most vulnerable clients including those at risk of poorest mental health outcomes.

Developing a mental health strategy

A mental health strategy development project was initiated in response to increases in the overall cost of mental health claims and recognition of the opportunity to improve client outcomes. This is a joint project between WorkSafe and the TAC.

The vision of the Mental Health Strategy is that:

“TAC clients and injured workers with mental injuries have access to the right intervention at the right time to enable independence and return to work”.

This statement reflects the overarching intent to make client needs and matching services the central focus of the strategy.

The Mental Health Strategy focuses on claims that have been accepted for primary mental injuries and secondary mental health issues as a result of physical claims. The synergies for the schemes are strongest across the management of claims regarding secondary mental health issues and broader clinical strategies for mental health services and supports.

The Strategy aims to achieve better mental health outcomes for individuals in terms of both their return to work and their general health post-claim whilst also seeking to achieve the best financial outcome for both Schemes. The post-claim focus includes secondary prevention. Its development was informed by a mental health advisory committee of external industry experts and business representatives. The committee offered a broad expert perspective regarding current gaps in the compensation environment as well as identifying links to existing alternate models of care in the public sector and the community. It was also informed by research undertaken in partnership with the Institute for Safety, Compensation and Recovery Research (ISCRR) into mental health and compensable settings.
Where to from here

WorkSafe and the TAC are very aware of the future challenges in enhancing mental health services and supports for injured workers and those injured in MVA. Both are committed to the implementation of strategic initiatives in these areas. The Mental Health Strategy details a range of potential new initiatives to implement across a three – five year timeframe. Current priorities include:

• Exploring models of ‘stepped’ care responses: in particular options for early support for those at risk of, or in early stages of mental health conditions.
• Enhancing the range and effectiveness of mental health interventions: review of psychology treatments to better align with clinical evidence and client outcomes as well as providing additional mental health interventions underpinned by psychosocial approaches.
• Empowering and enabling clients to better manage their mental health: educational and support models both face to face and technology based, premised on positive support therapy principles and self-management.
• Expanding vocational service options: increasing the range of vocational support services available and exploring different ways of increasing participation in employment.
• Increasing access to community based psychosocial supports: including group programs and activity-based services available in the community and activity-based services over and above clinical treatment.
• Feasibility of innovative commercial arrangements: to access public sector and community-based services.
• New and innovative partnerships: to develop the capability of WorkSafe and TAC staff and external providers, to effectively work with injured workers and those injured in MVA with complex and mental health related issues.

Conclusion

For WorkSafe and the TAC, operating within compensable settings, mental health injuries and mental health issues have traditionally been addressed primarily through a narrow offering of clinical and treatment service options. Notable gaps are in early support options, psychosocial supports and access to community based mental health services. The current approach also does not focus on early intervention and prevention of the development of secondary mental health conditions post-claim lodgement.

The proposed benefits of the implementation of new initiatives include:

• Improved client experience and client outcomes.
• Improved return to health.
• Improved return to work.
• Prevention of long term psychiatric disability or psychosocial issues.
• Positive impact on scheme viability for WorkSafe and the TAC and ultimately all Victorians.

The Health Services Group (HSG) is a collaboration group established by WorkSafe Victoria and the Transport Accident Commission that supports both organisations to achieve their corporate objectives of client outcomes/return to work, service support and scheme performance.

Research shows that individuals who do not have a compensable injury tend to show better overall outcomes compared with individuals with the same clinical profile who have a compensation claim.

YOUR SAY...
Member Profile

Dianella Community Health

Community Mental Health Service: ‘Improving My Health’ Group

James Fowles, Team Leader, Dianella Community Health, Community Mental Health Service

Dianella Community Health (DCH), Community Mental Health Service provides psychosocial support to 251 residents of the Hume community who have a diagnosed mental illness and are aged between 16 and 64 years of age and who are experiencing chronic and persisting mental health issues and complex needs.

DCH Community Mental Health Service is comprised of 14 multidisciplinary staff that deliver services through the following programs:

- Home Based Outreach Services (HBOS)
- Moderate Home Based Outreach Service (MHBOS)
- Intensive Home Based Outreach Service (IHBOS)
- Structured Day Program (Camp Road Site – Broadmeadows)
- Day to Day Living Day Program (Newbold Avenue Site, Craigieburn)

The DCH Community Mental Health Service works from a strengths based framework with a recovery focus working within a social model of health. Given that services are provided holistically, quality improvement measures are always being sought to improve consumer outcomes. In light of recent overwhelming evidence that people experiencing chronic and persisting mental health issues are likely to also experience physical health issues, DCH Community Mental Health Services has also been a key stakeholder in the Community Mental Health Programs and Service Coordination Initiative (CMHP & SCI).

In 2011-12 an internal audit of 20 consumers registered with the DCH Community Mental Health Services was conducted to determine:

- Does the consumer have any health concerns? If so what are they?
- Does the consumer have a chronic health issue? If so what are they?
- Is the consumer using DCH services other than the community mental health services?

The findings of the audit were as follows:\1:

- 80% had diabetes
- 80% had dental issues
- 80% were heavy smokers
- 70% were obese
- 45% had drug and or alcohol issues
- 35% had arthritis

45% were linked in with DCH Allied Health Services

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\1 Single identified conditions – not ascertained whether they are co-morbid or concurrent conditions.
The Improving My Health Group

In response to these findings, work was undertaken internally to improve consumer health outcomes. After considerable time and effort between the DCH Early Intervention and Chronic Care (EI & CC) Team and Community Mental Health Services it was decided that a joint initiative would be the best intervention strategy – a co-facilitated 12-week group program run by the DCH Health Coaches and Community Mental Health staff, Improving My Health.

The Improving My Health group was run over a 12-week period and addressed the following topics:

1. Diabetes education  
2. Smoking cessation  
3. I can make a change  
4. ABCs of healthy eating  
5. Reading food labels  
6. Let’s get moving  
7. Eating out  
8. Meal preparation and thrifty shopping  
9. Let’s get cooking without fat  
10. Celebrating accomplishments  
11. Graduation lunch

Evaluation and Findings

Pre and post program evaluations identified the top seven barriers to physical activity:

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Pre (%)</th>
<th>Post (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of energy</td>
<td>77.8%</td>
<td>44.4%</td>
</tr>
<tr>
<td>No one to exercise with</td>
<td>70.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Do not enjoy it</td>
<td>66.7%</td>
<td></td>
</tr>
<tr>
<td>Lack of motivation</td>
<td>66.7%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Busy with other things</td>
<td>66.7%</td>
<td></td>
</tr>
<tr>
<td>Feel unsafe</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>Poor health</td>
<td>44.4%</td>
<td></td>
</tr>
</tbody>
</table>

The evaluation also found that:

- **100%** of consumers would be interested in participating in a physical activity with others.
- **83%** of consumers had a waist measurement over 88cm
- **50%** of consumers would be interested in a walking group.
- **50%** of consumers would be interested in an activity with associated cost.
- **40%** of consumers had a fat intake score above 45 (Aim for a score of 45 or above)
- **0%** of consumers had a fibre intake score above 30 (Aim for a score of 30 or above)

General Feedback

Post program feedback revealed that consumers were making sustained changes to their lifestyle. Some of these changes were:

- Increased vegetable intake
- Reduced the portion size of meals
- Changes to the types of fats in their diet
- Walking further
- Getting more information out of the one session than ever from a doctor
- Only having Coca Cola when out at BBQ’s instead of everyday

Testimonials

Testimonial from Rosalie, consumer from the Camp Road Community Mental Health Program

- I now realise that I can’t sit in front of a computer all day and that I need to exercise. I’ve started using an exercise bike for 30 minutes a day.
- When I’m eating out, I know to eat healthy and to order healthy options from the menu. When I order pizza I order thin crust and only have healthy toppings e.g. no bacon, minimal cheese etc.
- I now read the labels when I do my shopping and if there’s a red tick I know that it’s been heart approved
- I have pre-diabetes and taken a lot out of the diabetes education. I now know that healthy eating is a lifestyle, and I make an effort to take my lunch with me so I don’t eat out and eat more fruit and vegetables.

The Improving My Health group is in its second term and will continue to run addressing consumer physical health interests.
EXPRESSION SESSION
Expression session

Michael Clay

MY WAY, in celebration on Mental Health Week, 2012

In celebration of Mental Health Week (8-24 October 2012), the MY WAY exhibition at the Cardinia Cultural centre showcased a stunning, vibrant and honest collection of works from artists living in the Cardinia, Casey and Greater Dandenong regions. This exhibition presented a group of artists who participate in Arts Access Art Classes, a visual arts program supported by Ermha Inc.

This exhibition boasted a 57 piece strong collection and celebrated the diversity of mental wellness and the importance of understanding the value of different perspectives in daily life. MY WAY was an exploration of the many and varied ways in which each exhibiting artist sees the world. As exhibiting artists they asked us, as the observer, to stand with them for a moment and see the world their way.
Michael Clay, a prolific and inspired artist and painter was well represented in the MY WAY exhibition with pieces exhibited at the Cardinia Cultural Centre, as well as in the MY WAY sister exhibition online at the Heist Gallery (www.heistegallery.com.au). Michael has been painting for 6 years now and is in the process of collating all his works, in the hope of curating his first solo exhibition in 2013. Of painting Michael says, “Sometimes when I feel a bit crook I start painting, I tried the jigsaw on paper first before painting on the board. With the jigsaw, if you make a mistake you can rub it out. Painting makes me happy”
Secret Squirrel Business was a delightfully surprising read. This self-help book, written by Australian consumer, film director and producer; author and researcher, Jenny Middlemiss, is all about surviving a diagnosis of mental illness, and the mental health system.

This colourful volume will be of benefit to mental health practitioners as well as consumers. Middlemiss has used her own experience of mental distress, many powerful personal stories from other contributors, and consulted and researched widely to bring together this accessible, practical, and thorough guide.

Secret Squirrel Business begins from the position of defining mental health and wellbeing, and questions the validity of the concept of normality, providing a really inclusive place from which to continue the book:

“Striving to be yourself, in all your different thriving colours, may be one of your main paths to wellness and recovery from mental illness. In other words, being mentally healthy is about being what is normal for you – not someone else.” (p14)

The book is structured into 14 chapters which take us on a tour of what it means to be distressed, get a diagnosis, find the road to recovery, care for ourselves, take control, and become ourselves in the truest sense. Each chapter ends with activities for the reader to complete on their own, and some reminder notes to stick on the fridge.

Refreshingly, Middlemiss doesn’t pretend to have all the answers, but provides a wide range of different concepts, resources and questions to enable people to find their own pathway to recovery. Although I must admit that on some topics I wanted to know her personal opinion in greater detail.

Middlemiss provides a clear overview of the different perspectives about mental illness causality, and encourages people to find their own truth. She also suggests that the reality around causality is most likely to be a complex interplay between many different factors.

The book’s approach to recovery is a good fit with the approach taken by community managed mental health (CMMH) services, and addresses the many different life factors that promote inclusion, meaning and recovery. I was particularly impressed with the thorough and eminently sensible guide to housing options, which included couch-surfing, living on the streets, and even prison.

I was also impressed with the honest description of what it’s like to be admitted to a psychiatric hospital, how the process works, the focus on loss and grief experienced as a result of diagnosis, and the practical explanation of different service types and treatments.

There is also a very sensitive chapter addressing sexual intimacy and romance where Middlemiss addresses intimacy as another form of exclusion and isolation.
Other ‘secret squirrel business’ includes practical advice about pensions, wanting to work, money, physical health, psychological health, and having fun. I can already imagine keyworkers across the country sharing many of the pages in these chapters with people at their programs.

Initially Secret Squirrel Business put me offside by calling itself a book for people with ‘enduring mental illness’. I, along with many other consumer activists, have some issues with how this term can be used in excluding and minimising ways. Yet on reading the content I found a much more inclusive text that would apply to anyone: ‘Each person’s illness is hard for them. Whether it’s serious or moderate in professionals’ eyes, to that person it is painful and horrible, we are different to the rest of the world.’

I found that Middlemiss included a great range of different perspectives about mental illness causes and treatments, yet sometimes within each chapter the variety of views were not always apparent. For example while reading the chapter about medication I felt the book took a fairly strong ‘risk management’ position. Yet in another chapter Middlemiss comments that ‘Just popping pills won’t make you well. They can help but if underlying issues in your life aren’t resolved they will keep coming back.’ (p113). Something I’d love to see in the next edition is some more comprehensive internal cross referencing.

The illustrations by Roy Husdell and cartoons by Leunig interpret the content with sensitivity and gentle humour, while the online site design is punchy, clean and easy to navigate.

I commend Jenny Middlemiss for this valuable and comprehensive work, and suggest that Ruah Community Services be congratulated for supporting the development of this resource which will be of benefit to so many.

Secret Squirrel Business is available as a free download from www.secretsquirrelbusiness.com.au

FIND OUT MORE: For more information about Indigo Daya, please visit www.indigodaya.com. For further information about Voices Vic, please visit www.voicesvic.org.au.
**ABOUT US**

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.

**Our Vision**

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.
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