REFRAMING MENTAL HEALTH: A NEW STATE OF MIND
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• Letters to the editor should be under 300 words.

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REFRAMING MENTAL HEALTH: A NEW STATE OF MIND

It is a taster for those of you attending the conference and an opportunity to engage with the leading edge thinking that will be on show for those of you who can’t make it. We are delighted to have as our lead article a message from the Victorian Minister for Mental Health, the Hon Mary Wooldridge MP. In it she outlines the government’s new reform framework for the community managed mental health sector. Minister Wooldridge will make an address to the conference about the reframing of mental health to better meet the needs of individuals with complex needs, their families and carers.

Although she can’t be with us in person, one of VICSERV’s favourite thought leaders, Mary O’Hagan from New Zealand agreed to write for this edition. Her piece calls on us to reframe the old ‘fading life chances’ story of mental illness that she was given as a young woman to a story that frames madness as a profoundly human crisis of being from which we can derive value and meaning. She asks, ‘how do we generate a new story of madness that most people sign up to?’ The answers are inspiring.

VICSERV CEO Kim Koop and I have co-authored an account of the development of a paper that recommends a program of reform for the community managed mental health services in Victoria. The Agenda for the future is VICSERV’s major strategic and advocacy policy. It was developed with and on behalf of our members. It will guide our work for the next three to five years and inform our response to the Victorian Government’s Psychotic Disability Rehabilitation and Support Services Reform Framework.

Neami CEO Arthur Papakotsias has written an account of the recent merger between Neami and another community managed mental health service. It provides great insight into the process that was involved and the lessons that were learnt. Arthur and Mind Australia CEO Gerry Naughtin will be presenting at the conference on their experience with successful mergers and the benefits for consumers, carers and staff.

One of the conference sub-themes is consumer leadership and will feature a diverse range of speakers on inspirational topics. Two CEOs from the Mutual Support and Self Help Network, Anne Wicking and Frances Sanders make a compelling case in this edition for the role and importance of peer support in the reform process. Housing and homelessness is another conference sub-theme and Emma Ladd from the Mental Illness Fellowship of Victoria introduces an exciting innovation in providing housing and support to people with a mental illness. The Doorway program will be showcased at the conference. Doutta Galla Community Health Service is one of a number of organisations that are using the Collaborative Recovery Model (CRM). Read how they have incorporated the model into staff coaching.

The equal pay case for community workers has generated great interest for those who will receive the pay rise and for those who will fund it. We are pleased to have an analysis from VCOSS on how it came about and what it means for the community sector.

One of the most significant pieces of mental health research in recent years is the 2010 Survey of high impact psychosis. It is 10 years since the last survey and while there have been impressive improvements in some key domains of everyday life: inequality and social exclusion is still a feature of the lives of people with a psychotic illness. Professor Vera Morgan presents some of the survey results in our research section.

As always, I am extremely grateful to all the contributors who make up this edition. newparadigm provides a record of achievement and aspirations which is especially valuable as the sector enters a period of major reform.
The Victorian Coalition Government’s release of a major consultation paper to drive reform of state-funded Psychiatric Disability Rehabilitation Support Services marks the first stage of an exciting and challenging period of change designed to deliver better outcomes and more targeted and accessible services for people with severe mental illness and their carers across Victoria.

Victoria has a diverse and vibrant community-based mental health sector and the Victorian Coalition Government sees these services as a vital part of the mental health system.

More than two decades following the de-institutionalisation of people with a mental illness, more and more Victorians with a mental illness are being supported to live in the community. This change has seen communities develop a greater understanding of and responsibility for mental health.

As governments witness the positive outcomes of de-institutionalisation and community based mental health care there is always a need to continue to improve and evolve.

In many ways, de-institutionalisation was successful due to the strength and fundamental role of Victoria’s community based mental health services, or more formally, the Psychiatric Disability Rehabilitation Support Services (PDRSS). Without the dedication and commitment of our PDRSS sector, mental health care in Victoria would be in a very different place.

The State government spends more than $100 million each year to support more than 14,000 Victorians that are supported by over 100 community based mental health services. This support can also be in the form of linking people into housing, employment, education and family support – all of which contribute in a big way to assisting someone in their path of recovery and re-building their lives.

As our reliance on our community based mental health sector continues to grow, governments must continue to create opportunities for innovation, growth and development. Individuals, families and carers want higher quality services that are more flexible, individually tailored and responsive.

The Coalition Government wants to work in partnership with Victoria’s PDRSS sector to reform and build sustainable and strong community mental health services for the future.

Embarking on a comprehensive reform agenda across a sector as large and diverse as the PDRSS is not something that we do lightly. We are confident that the sector is resilient and ready to embrace the challenge and become stronger as a result.

It is often when a particular service sector has reached a critical point in its growth and success that reform is most needed and that the opportunities for benefit are greatest. That is now the case with our PDRSS sector.

The Coalition Government’s consultation paper Psychiatric Disability Rehabilitation and Support Services Reform Framework seeks your views on how we can achieve our vision in reshaping community based mental health services to ensure better outcomes for people with a mental illness.

Ad hoc investment by governments over time has created an unsustainable situation with many agencies unable to provide adequate choice and flexibility for individuals and families.

At the heart of our reform agenda is the need to offer a more consistent, flexible, tailored set of supports that meet the needs of individuals and families. This must include a sharper focus on both individual goals and key aspects of social and economic participation.

In order to achieve this, the reform program will work simultaneously on three levels.

First, we will work to enhance the capacity of organisations so they are stronger and more sustainable. This means investing in the PDRSS workforce, delivering better governance and improving accountability around outcomes of clients accessing services.

Second, we will remodel programs so that they are flexible and encourage innovation and choice for people accessing services. We want programs and services that are effective, work in a coordinated way with the full range of other health and social services and are responsive to the individual needs of a person with a mental illness.

Finally, we will streamline services so that they are of a higher quality, accessible and more efficient. We need to invest in building a system that is able to meet the growing number of people who will access community based mental health care.

This is not an agenda that government can or should pursue alone. The outcomes we seek will only be achieved through close partnership with delivery agencies and other stakeholders. I very much look forward to working with a wide range of participants in this sector. I am particularly keen to hear from service users, their families and carers as we reshape the way community based mental health care looks like in Victoria.

Our partnership with VICSERV is critical to this agenda. I congratulate VICSERV for the recent release of its own discussion paper on the challenges for the community-managed mental health sector. That paper shares many conclusions of the government’s paper. This broad consensus on direction sets a sound base for the work ahead.

This kind of reform is not easy. The Coalition Government is committed to an open, transparent and consultative approach at each stage. I am confident that together we can achieve an even better, stronger system of community-mental health support services.

An Agenda for Change – reforming Victoria’s Psychiatric Disability Rehabilitation Support Services

The Hon Mary Wooldridge MP, Minister for Mental Health
A new story for a new leadership

Mary O’Hagan, International consultant in mental health and recovery

The leadership of people with lived experience in their own recovery, in service delivery and in the wider system is just a side-show, while the dark drama of a disempowering and hope-sapping mental health system plays on to full houses of captive consumers year after year.

The old story

When I used mental health services as a young woman I was given a ‘pills and pillows’ service and a ‘fading life chances’ story; the idea that people like me could lead in any sense of the word was as unimaginable as gay marriage or downloading a movie. Most of my paid helpers were good people who tried to help me but failed because they approached me with a depleting blend of pessimism and paternalism. They occurred to me as chronically disabled by a chemical imbalance in my brain. None of them acknowledged my strengths or the skills and wisdom my lived experience gave me. None of them even told me I could go on to live a full life. My only role models were people like me whose lives were consumed with crises and hospital admissions. I don’t recall any mental health workers openly acknowledging their lived experience. I don’t remember any mental health workers asking me if services helped me. It didn’t occur to me that people with lived experience could run their own services or support networks.

How things have changed in the last 20 or 30 years. We now have recovery, peer support, consumer-run organisations, consumer participation policy, and consumers working in management, research, training and policy. There’s a catch though – these developments have affected very few consumers’ lives. Many don’t know about recovery or their right to participation. Very few have access to peer support or have heard of the consumer movement. Many are still disempowered, mired in an ‘illness’ identity, stuck in services, and marginalised in the community.

The explanation for this is obvious: the leadership of people with lived experience in their own recovery – in service delivery and in the wider system – is just a side-show, while the dark drama of a disempowering and hope-sapping mental health system plays on to full houses of captive consumers year after year. People with lived experience, the mental health system and wider society need to co-direct a new play for the main stage in which people with lived experience are the protagonists with the most quoted lines, rather than the victims or the villains lurking off-stage.

A new story

At the most fundamental level, the new production needs to tell a story about madness that releases professionals from the ‘fading life chances’ story, and communities from their prejudice and fear. It has to be a story that frames madness as a profoundly human crisis of being from which we can derive value and meaning. There is an archetypal template for this type of story which the mythologist Joseph Campbell called the hero’s journey. He found that, in the stories of many cultures, the heroes depart from the world they know and become lost in a perilous place where they face many tests that stretch their resources to the limit. They eventually find their way out of peril with wounds but also with new knowledge and skills, then make the arduous return journey to the known world, where they use their learning to make a new contribution. The hero leads their own journey but someone who has been subjected to the fading life chances story has nothing to lead. A hero needs empowerment and resources whereas someone with fading life chances merely needs ‘maintenance’ supports or ‘palliative’ care. It’s easy to see that the story we tell about madness has huge implications for the way we respond to it.

A new story would enable us to take on new roles and identities. It would give permission to people with lived experience to lead their own recovery – to be active agents in their lives rather than passive recipients of treatments, services and poor prognoses. It would take mental health workers out of the driver’s seat where they habitually steer, control and do things for people, into the passenger seat where they have to learn to simply navigate and support. At the individual level, mental health workers would give priority to earning trust and developing collaborative relationships with consumers rather than ignoring their humanity, erecting ‘professional boundaries’, or habitually resorting to coercion.

A new story also would have huge implications for the distribution of power at all levels – away from decisions and resources dominated by professionals and managers towards the people making the hero’s journey, who need all the empowerment they can get to complete it. At the service or system level a hero’s journey story would show us the importance of democratising our services and systems so that people with lived experience would have a genuine voice in decision making and resource allocation. A new story based on the hero’s journey would encourage the mental health system to employ many more people with lived experience in all kinds of roles – as peer workers and as bureaucrats, managers, academics and professionals.

A new story would give the mental health system an urgent incentive to offer a range of services that enable people to lead their own recovery and make progress with their hero’s journey. These include peer support, recovery education, support in education, jobs and housing and humane options in a crisis.

Finally, a new story would make stigma and discrimination against mad people as untenable as it is against other people who make hero’s journeys into the unknown, such as soldiers, mountaineers, fire fighters, artists and monks.

How do we generate a new story of madness that most people sign up to? The story needs to transform everything we feel, think and do. The story also needs to inform every level of the mental health system and every communication we make with our communities. One of the most direct ways to transmit the new story is through education. People with lived experience, their families, mental health workers and community members all need re-education to give them new awareness and skills at the individual level and when working at the service or system level.

New competencies to support individuals

All the major stakeholder groups need a new set of competencies to support individuals to lead their own recovery. Many of these competencies needed by people with lived experience, their families and friends, mental health workers and community members are similar.

People with lived experience

To lead their own recovery, individuals with lived experience need to become competent at believing in themselves, managing their lives and their relationships, and using the resources that are useful to them. For instance, they need to:

• make sense of their experience in a recovery framework
• resolve internalised stigma
• recognise their own strengths and expertise
• acquire skills in self-management
• know about service options, treatments and rights
• know how to get the most out of services and community resources
• have positive communication and assertiveness skills
• have negotiation and collaboration skills.

Families and friends

Families and friends also need to become competent at sustaining hope for the person with mental distress, supporting their recovery and understanding that they may be on their own separate recovery journey. They need a similar set of competencies to people with lived experience as well as the ability to:
• resolve the grief, shame or anger they may feel about their relative
• support the person to lead their own recovery
• lead their own recovery as a family member.

Mental health workers
Mental health workers need to be collaborative, flexible, respectful, and empowering. In addition to directly developing the competencies of people with lived experience to lead their own recovery they need to:
• show respect for the madness experience
• know and apply recovery principles in their work
• understand people in the context of their whole lives
• develop partnerships with people, their families and other services and community resources
• prevent and provide alternatives to compulsory or coercive practices
• have positive communication and assertiveness skills
• have negotiation and collaboration skills.

Community members
Individual members of the community who do not have lived experience or family experience need to:
• understand madness as part of the human condition
• know how to respond in an empowering way to people in deep distress
• have exposure to positive stories about madness
• have positive contact with people with lived experience
• know that discrimination against people with lived experience is not tolerated
• welcome diversity in their community.

New competencies to work at a service or systemic level
Some of us in the stakeholder groups do work for the collective good at the service or system level in many different roles. We need all the individual level competencies as well as competencies related to our particular roles; we also need additional professional competencies to support the new story of madness and the leadership of people with lived experience.

People with lived experience and their families
People with lived experience and families may participate in the planning, development, delivery and evaluation of services and systems as volunteers or employees in a wide variety of roles. They need to develop competencies to enable them to amplify the voice and advance the interests of their stakeholder group. For instance they need development in the following areas:

Personal
• understand and learn from their own or their family member’s distress and recovery
• acquire skills in self-care in life and at work
• possess self-awareness and skills in reflective practice.

Knowledge
• understand the values of the consumer movement and/or family movement
• understand recovery principles and practice
• know about helping systems
• know about critical perspectives in mental health.

Skills
• know how to use self-disclosure for the benefit of others
• encourage others to use their strengths and resources
• enable consensus or autonomous decision-making
• relate as equals to diverse groups of consumers and families.

Mental health professionals and managers
Mental health workers also need new competencies for a new leadership. They need many of the same competencies as people with lived experience and their families who work at the service or system level as well as the ability to pass on these competences to service users and families. In addition they also need to:
• know and respect ‘lived experience’ perspectives and expertise
• work in partnership and with accountability to clients and their families
• practise zero tolerance of discrimination and abuse within services
• ‘come out’ as a person with lived experience if this is part of their life story.

Community leaders
Community leaders include politicians, media commentators and opinion leaders. They articulate community views on mental health issues. These leaders need to:
• understand mental health issues from human rights and social justice perspectives
• practise zero tolerance of discrimination
• make supportive public statements
• ‘come out’ as a person with lived experience if this is part of their life story.

To finish...
Developing these competencies through education will allow us to ditch the old script and stage directions and give us new ones. Our performances will demonstrate supportive beliefs about madness, model new identities and roles, equalise power dynamics, value and develop a workforce with lived experience, and open the way to a broader range of services. Only then will the leadership of people with lived experience come on to the main stage.

This was reflected in supportive policy and significant funding commitments. Consumers and carer advocates were enthusiastic about psychiatric disability being included in a proposed National Disability Insurance Scheme (NDIS). In amongst it all, the unique contribution and philosophy of community managed mental health was being recognised. In a joint statement, Federal MP Nicola Roxon, Jenny Macklin and Mark Butler stated:

As important as clinical treatment is, other services and support in the community are also critical for the recovery of people with mental illness — to participate in social and community life, get and keep a job, improve relationships with family and friends and help manage the tasks of everyday life. The budget includes substantial additional funding for community-based mental health support including Personal Helpers and Mentors and essential respite support.1

In Victoria the Liberal Nationals Coalition released a mental health policy statement which said:

Victoria has developed a good PDRSS sector, but further investment is needed to build capacity of organisations providing services to young people, adults and older Victorians. A stronger PDRSS sector will be effective in supporting people and their families in their homes to manage and recover from mental illness, and in so doing, reducing the demand for acute services.2

It was in this positive environment that the VICSERV Board concluded in April 2011 that a Strategic Directions Subcommittee was to oversee the development of a consultation paper. The VICSERV Agenda for the future3 (the paper) was released in February this year and a period of extensive consultation concluded in April.
One of the major findings from the research and analysis was that most CMMH agencies, both small and large, receive only small amounts of state government mental health funding. Of the 130 agencies, accessing PDRSS funding, 73 receive less than $500,000 and 33 receive less than $100,000.

In reframing the CMMH service system, the paper looked to the future. Three key trends were evident:

- funding for mental health services provided in the community is expected to significantly increase beyond the next few years due, in large part, to the Federal Government’s Australian Mental Health Initiative and the introduction of an NDIS;
- the shift towards individualised and tailored service offerings which had commenced with the introduction of Home Based Outreach Service (HBOS) is set to continue and be fully realised under the proposed NDIS model;
- consumers and carers will have increasing control of how their funding dollars are spent and will be demanding value for money, choice, flexibility, quality and accountability. This will lead to a more market-based approach to service delivery. Block program grants will largely be replaced by individual payments and competitive pricing. New and for-profit providers may enter the market.

It is in this context that the paper calls on the Victorian State Government to develop a new program and funding structure. Existing program guidelines have generally not been reviewed for many years and, as will be discussed further, funding allocations have typically been made on a historical and ad hoc basis rather than a planned and rational approach. The paper puts forward a high-level approach oriented towards the future.

During consultations on the paper many participants confirmed that the stakes were incredibly high for CMMH now and into the future. Greater choice and control for consumers was consistent with the sector’s philosophy and major funding investments in programs were welcome. However, many had experienced what happened in other sectors when new funding and service delivery models were introduced based on these and similar trends. Agencies lost funding, some were forced to close. Of greatest concern was that people in need received a reduction in hours of service or missed out entirely. This led to some anxiety and created a sense of urgency that the extent and timing of reform needed to be sufficient to minimise these risks or avoid them all together. The paper’s recommendation for a state government funded trial of individual packaging was well supported.

The scan of the policy and funding environment and of future trends likely to impact on the CMMH service system concluded that agencies of the future would need to be capable of:

- providing a broad range of services tailored to individual and changing needs;
- using budgets flexibly to deliver a number of service types as part of an integrated suite and/or;
- providing a specialist or niche service based on a defined recovery orientated logic;
- operating planning, financial management, ICT and reporting systems that are able to meet the requirements of many different funding streams;
- developing business models to operate efficiently in a competitive market place;
- developing strong partnerships with multiple stakeholders;
- recruiting and retaining a workforce with appropriate skills and knowledge.

In order to encourage agencies to reframe their business and strategic planning in line with future demands the paper puts forward a self-assessment framework to capture these and other capabilities. Chief amongst these was the financial bottom line. Future capability depends on a robust balance sheet and multiple revenue streams.

One of the major findings from the research and analysis undertaken for the paper was that most CMMH agencies, both small and large, receive only small amounts of state government mental health funding. Figure 1 (next page) shows the details. Of the 130 agencies accessing PDRSS funding, 73 receive less than $500,000 and 33 receive less than $100,000. The paper drew no specific conclusions regarding the desirable size of agencies or the size of their budget.

The question was reframed in the context of capability. VICSERV has recommended that the Department of Health fund it to work with agencies to increase their capability and capacity to thrive in the future.

The future trends identified above point to the need not only for agencies to be capable but that they are configured as part of a rational service system delivering the full range of services that consumers and carers require where and when they are needed. Consumers, carers and workers have consistently reported the complexities of navigating the current CMMH service system. Part of the difficulty is that historic funding patterns have led to an uneven spread of service offerings across geographic areas and program types. This has been further complicated by allocations of Commonwealth funds often not being made on the basis of local need or capacity.

Victoria is not alone in having a fragmented system and significant attempts have been made to address the issue. However, change has not been achieved on the scale that is required for the individualised and market-based environment of the future. VICSERV has recommended that the Department of Health in its role of systems manager, commission a local area planning project.

CMMH agencies that have made a thorough assessment of their capability and are aware of their strengths and any weaknesses will be in a strong position to participate in local area planning. Once the current and future needs of an area have been established the paper outlines a number of pathways to create a more rational service system that is easy for consumers, carers and others to navigate. This might involve sharing back of house functions, co-locations, pooling resources, alliances and potentially, mergers. VICSERV considers that a more rational approach to across geographic planning is a key building block for the future. It recognises the diversity of agencies and auspices involved and the complexity of reaching agreement about the required planning and authorising processes. It will require active engagement from Boards and the Department of Health as the funding body.

At the time of writing, the state government is about to release a mental health strategy and PDRSS reform framework. These documents have been much anticipated. VICSERV has worked collaboratively with the Victorian Department of Health over the last few years in mental health reform and partnership groups and projects. Its own reform paper has been enriched and informed by these collaborations and discussions. To continue the momentum and maintain the dialogue, VICSERV recommends the appointment of an Ambassador for Community Managed Mental Health. It also recommends that the term PDRSS is no longer used to refer to the service system collectively. It is the name of a funding stream and does not reflect the distinctive role and purpose of agencies that are managed by voluntary Boards to provide recovery-based services in people’s homes or close to where they live.

The program of reform outlined in the VICSERV Agenda for the future will assist with reframing the perception of CMMH from a bit player in the specialist mental health service system to an industry in its own right thinking in a radically altered environment. The key driver for change is to capitalise on the opportunities that will arise to significantly improve the lives of consumers and carers.
Managing a merger

This article provides a narrative account of the recent merger of the Inner East Mental Health Service Association (IEMHSA), a government-funded not-for-profit organisation providing psycho-social rehabilitation services in four municipalities in Melbourne’s inner eastern suburbs, with Neami, a non-government mental health organisation providing rehabilitation and recovery support at 26 branches across north-eastern Melbourne, New South Wales, South Australia, Queensland and Western Australia.

In April 2012, we celebrated the first anniversary of the successful merger and a process which has provided a valuable and positive learning experience.

I hope this article facilitates useful discussion and reflections about the relative merits of mergers as well as some of the unique challenges. It aims also to foster an understanding of the successful process we undertook, whilst acknowledging that ‘one size does not fit all’.

The beginnings

I returned to Melbourne in mid-2009 after living in Sydney for two years to oversee the development of Neami’s Housing and Accommodation Support Initiative (HAS). After early consultations with departmental staff, local clinical leaders and sister non-government organisations, it became evident that there were concerns at very senior levels within the Department of Health regarding the viability of the Psychiatric Disability Rehabilitation and Support Services (PDRSS) sector, in particular for a number of smaller agencies. It appeared that historic organic growth in the sector had come under scrutiny, with a view emerging that, in order to develop the sector, agencies had to operate at a larger scale, possess greater infrastructure and have increased capacity to address the growing quality improvement requirements and contract compliance responsibilities.

One of the meetings during this time was with the CEO of Inner East Mental Health Services Association (IEMHSA), an organisation with which Neami had enjoyed a long-term, professional relationship. Often discussing trends in the mental health sector, we began to realise the shared values evident in each organisation.

Discussion continued when the newly developed IEMHSA Strategic Directions were released, expressing issues of viability and the subsequent need for improved partnerships and to build capacity. We began to canvass the question: what would a partnership or alliance between Neami and IEMHSA look like?

After detailed discussion, the IEMHSA Board agreed that further exploration of this issue should occur and the relative merits of a partnership were postulated at a number of formal and informal meetings. It was during one of these that the word ‘merger’ was used. The next step was to take the issue to the Neami Board to confirm whether Directors wished to explore the desirability and feasibility of a merger with IEMHSA. The result was positive.

The process

With support from both Boards, a mutually-agreed external consultant was appointed and asked to facilitate a workshop between senior managers and Board Directors from both IEMHSA and Neami to allow each organisation to put their ‘cards on the table’: that is, declare their ‘negotiables’ and ‘non-negotiables’, clarify and hopefully agree on a ‘value proposition’ and, if all parties were still happy to proceed, map out a process including tasks and timelines.

The workshop turned out to be a milestone event in assisting the merger process. As a larger, national organisation, Neami made it clear that our ‘non-negotiable’ was that IEMHSA would become a part of Neami and that IEMHSA, as it was known, would cease to exist. The other option explored – that of merging the two organisations together to form a new one – was rejected by the Neami Board.

It became clear that, with an operating budget of around $3 million, IEMHSA struggled with inadequate infrastructure and operational capacity to achieve the organisational improvements it desired. IEMHSA also acknowledged that the Eastern and Inner Eastern suburbs of Melbourne were a very crowded PDRSS space that was highly competitive – growth opportunities were limited. IEMHSA indicated its desire to be part of a national organisation and have access to staff training, including in an evidence-based service model of recovery, such as the Collaborative Recovery Model (CRM) which Neami utilises.

In late 2010, Neami had an operating budget of around $30 million, as well as national coverage. This meant it had the capacity to diversify its funding sources whilst maintaining a clear focus on working with people with a serious mental illness, providing it with relatively good growth prospects.

The mutually agreed ‘value proposition’ was to provide the best possible outcomes to people with a mental illness living in the eastern suburbs. A successful merger therefore would address some of the concerns about capacity and infrastructure raised by the IEMHSA Board and senior management. But what about the benefits for Neami?

Reflection on Neami’s mission of ‘improving mental health and wellbeing in local communities’ and genuine belief that consumers of IEMHSA would benefit from Neami’s model of service delivery (CRM) and integrated approach to service delivery (see break-out) was enough to satisfy the value proposition.
The other two critical issues were: the need to undertake a financial and legal due diligence exercise as well as an exploration of the respective cultures of each service. The financial and legal issues were resolved fairly easily, notwithstanding some capacity issues in dedicating resources and time to these issues whilst still operating a service at full capacity. Similarly, the cultural fit was assessed as excellent, an almost perfect match in both organisations; direct care staff visited each other’s respective services to see how services operated, how staff interacted with each other and with consumers. Staff were keen to try new ways of delivering services and were very committed to consumer-directed services.

The decisions

In February 2011, both Boards made independent decisions that the merger should proceed. It was agreed that IEMHSA would become a part of Neami, that all IEMHSA staff managing and providing services were to be offered ongoing employment with Neami and, that IEMHSA would be wound up as a legal entity. (Just prior to that winding up, an IEMHSA Board Director was appointed to Neami’s Board.)

Three IEMHSA head office staff, including the IEMHSA CEO, were not offered ongoing positions, as these roles would not be required in the merged organisation. Such decisions can be very difficult for all parties involved, however each of the three managers demonstrated integrity, honesty and a high respect for consumers, and it is pleasing to see some of them continuing to play vital roles in the Victorian mental health sector.

After the merger decisions were made, a communication strategy was implemented to ensure a clear and consistent message was provided to consumers and carers, staff, clinical, housing and other partners, and funding bodies.

Communication with staff at the IEMHSA was most critical in conveying what would change, over what time, and how. We had a high degree of clarity and planned the transition process very thoroughly. An important timing factor was the funding bodies’ ability to transfer IEMHSA contracts and funding to Neami. From Neami’s perspective a quick transition was much better than a lengthy one.

The merger

On 1 April 2011 Neami assumed management of IEMHSA. The IEMHSA Board continued to maintain overall governance responsibilities until the transfer of funding contracts was complete, however Neami put in place a management structure to ensure services continued and staff were

It appeared that historic organic growth in the PDRSS sector had come under scrutiny, with a view emerging that...agencies had to operate at a larger scale, possess greater infrastructure and have increased capacity to address the growing quality improvement requirements and contract compliance responsibilities.
Peer support: an integral part of mental health services

The Victorian Government has stated in its strategic priorities its commitment to ensuring people with a mental illness receive involvement of the individual in recovery services, defining its purpose in the following way:

‘In the paradigm of mental health, the concept of recovery is understood to refer to a unique personal experience, process or journey that is defined and led by each person in relation to their wellbeing. While recovery is owned by and unique to each individual, mental health services have a role in creating an environment that supports, and does not interfere with, people’s recovery efforts. To this end, the Framework for Recovery Oriented Practice explicitly identifies the principles, capabilities, practices and leadership that should underpin the work of the Victorian specialist mental health workforce.’

Within this framework, the Literature Review identified important components of recovery-oriented practices in organisations. These included:

• a peer support workforce
• involvement of people with lived experience and their significant others in processes such as recruitment, education, training and development, and quality-improvement activities
• responsiveness to people’s feedback; for example, through using outcome-measures, surveys, quality audits, complaints, service planning and evaluation activities and training led by people with lived experience.

(Victorian Department of Health, 2011, Framework for recovery-oriented practice p1, p4)

Addressing these needs, and of particular importance in any reform, is peer support. It delivers a client centred approach to recovery, embraces self-direction and management, provides a well-resourced and integrated continuum of care that focuses on a client-centered approach to recovery, including the development of self-management and inclusive practice.

In terms of early intervention and prevention, peer support provides unequalled access to support, knowledge and referral in a way that respects and upholds the knowledge of the individual. In reducing the isolation and stigma associated with the experience of mental illness, it provides a powerfully salient model, increasing a sense of mutuality, personal empowerment and community connection.

Within the new mental health framework, peer support needs to be considered as a vital pathway to recovery that supports social inclusion and wellbeing. This article examines the current policy framework for mental health recovery in Victoria, and the role peer support should play in that environment.

Mental health framework

In 2011 the Victorian Department of Health released the Framework for Recovery Orientated Practice which focused attention on the unique journey and involvement of the individual in recovery services, defining its purpose in the following way:

‘The Victorian Government has stated in its strategic priorities its commitment to ensuring people with a mental illness receive help earlier, and that the treatment and support they receive effectively reduces the often devastating social and economic impacts of mental illness. The 2007 National Mental Health and Wellbeing Survey found that one in five Victorians aged between 16 and 85 years suffer from a mental illness at some stage in their lives. An estimated 4.6 per cent of the Victorian population – just over 250,000 people – experienced a severe mental illness or substance use disorder each year. A further 16 per cent experienced a moderate or mild mental health problem.’

Department of Health, The Victorian Mental Illness Research Fund, (p4)

In Victoria, there is much discussion on the reframing of the mental health sector, with the State Government recognising the magnitude of support that is needed. More than ever before, we need a mental health services system that:

• caters for a diverse range of mental health illnesses and issues
• meets a diverse range of need
• adopts early intervention strategies (both early in life and early in episode) for both consumers and carers
• provides a well-resourced and integrated continuum of care that focuses on a client-centered approach to recovery, including the development of self-management and inclusive practice.

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(2011, Framework for recovery-oriented practice p1, p4)

Addressing these needs, and of particular importance in any reform, is peer support. It delivers a client centred approach to recovery, embraces self-direction and management, provides a range of choices, encourages family inclusive practice and has a focus on building capacity – individually and within communities.

Role of peer support

Peer support is well described by Borkman (1976, p 446) as: “Experiential knowledge is truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others.”

It is in this description that we find the essence of ‘lived experience’ and the value it can add in mental health recovery. For too long the value of the individuals’ experiences in guiding their own recovery and wellbeing has been under-valued and, in some cases, discounted. In fact, we have too often deferred to ‘discursive reasoning, observation or reflection on information provided by others’ to inform practice.

Peer support services have grown, in Victoria and elsewhere, over the years because they have filled an important gap in the service structure. Many peer support (or Mutual Support and Self-Help) groups were formed as a result of the lack of access to mental health services. In terms of early intervention and prevention, they provide unequalled access to support, knowledge and referral in a way that respects and upholds the knowledge of the individual. In reducing the isolation and stigma associated with the experience of mental illness, peer support provides a powerfully salient model, increasing a sense of mutuality, personal empowerment and community connection.

The need for peer-based interventions is both an outcome-based and economic imperative. Studies suggest that the use of peer support can help reduce the overall need for and use of mental health services over time (Chirman, et al, 2001; Klein, Cain, & Whitecraft, 1998; Simpson & House, 2003). The use of a peer support specialist as part of treatment has been shown to deliver a range of favourable results (Daniels, 2010), while information provided by peers is often seen to be more credible than that provided by mental health professionals (Woodhouse & Vincent, 2006).

In other modern mental health systems, a vision for the future has engaged consumers and carers as the experts in their own services and recovery. The Surgeon General Report (1999) demonstrated that there were well documented evidence based treatments in mental health, and a range of treatments exists for most mental disorders. The report also presented findings that self-help and mutual support, from which peer support services have evolved, was the fastest growing service.
The launch of the Centre of Excellence in Peer Support (Mental Health) and release of the Charter of Peer Support in 2011 were important steps in advocacy for the inclusion of peer support in service provision by government and not-for-profit providers in the mental health sector.

for people in recovery, Victoria has for many years led Australia in its aspirational progress towards peer led supports and interventions.

The valuable role that peer support plays in the recovery and wellbeing of individuals is shown in the recent increase in funding to peer support groups for people experiencing chronic physical illness in Victoria and the expansion internationally of peer support funding. Within the new mental health framework for Victoria, peer support needs to be considered not only as a ‘growth’ service but a ‘foundation’ to support people with mental health illness and issues.

Peer support advocacy

The launch of the Centre of Peer Support and Advocacy (Mental Health) and release of the Charter of Peer Support in 2011 were important steps in advocacy for the inclusion of peer support in service provision by government and not-for-profit providers in the mental health sector in Victoria. Written by consumers and carers and now endorsed by a not-for-profit providers in the mental health sector in Victoria.

Written by consumers and carers and now endorsed by a not-for-profit providers in the mental health sector in Victoria.

by Anne Wicking and Frances Sanders

Opportunities to understand and destigmatise mental health issues

Opportunities to benefit from collective wisdom

Opportunities to support as either a stand-alone or part of a continuum of care

Opportunities to receive hope, inspiration and empowerment for recovery/healing

Opportunities to provide help to others, as equal-to-equal

A unique pathway to help.

Most of Victoria’s specialist PDRSS mental health services were established by people with lived experience who could not find the help they needed elsewhere. These have been providing support for 30 years or more for a range of mental health issues that confront consumers and their carers. Peer support as either a stand-alone or part of a continuum of care is an integral gateway and pathway for Victorians who experience mental health issues and their families and carers.

References


The model

Having a real home provides a space for people to connect with friends and family, find work, improve health and well-being and build a life. Doorway builds on the successful Housing First model, which has demonstrated that people with mental illness who have been homeless are able to maintain tenancies when provided with housing and personalised support (Gulbur et al, 2003, 2007). It has also demonstrated that timely access to housing reduces incidences of hospitalisation and the need for acute treatment (Sadowski et al, 2009). However, the model has also attracted criticism: Fyans et al (2007) reported that people interviewed from a Housing First program were in stable housing but appeared to live ‘lives without any involving pursuits or set of meaningful
connections’. Padgett (2007) likewise notes that ‘other core elements of psychiatric recovery such as hope for the future, having a job, enjoying the company and support of others, and being involved in society... have only been partially attained’. To build on the gains that nonetheless are made when stable housing is attained, the Doorway program is designed to increase confidence and self-efficacy for participants and to promote genuine and sustainable social inclusion.

A key difference under the Doorway program from the traditional Housing First approach lies in working with people to negotiate the private rental market as part of finding a home. Developing a solid tenancy history enables people to avoid the potential limits of living in social or supported housing, and broadens their options for creating real homes now and in the future. Going through the process of identifying preferences and applying for properties can also build confidence in people who may have had little or no choice or control over past housing environments. Doorway supports participants to identify what ‘home’ is for them – whether this means having a dog, living with a partner or children, or being close to a sports club. Being able to choose their own place means people feel more connected to and invested in their home, increasing the likelihood that the tenancy will be sustainable.

Today’s rental market can be highly competitive and many of the participants in Doorway have struggled to be considered for private rental housing due to stigma and the requirement for prospective tenants to demonstrate a stable rental and employment history. Doorway aims to develop partnerships with real estate agencies and landlords to address some of the private rental barriers that people with a mental illness face. The Real Estate Institute of Victoria (REIV) has been an enthusiastic supporter of Doorway, detailing the benefits of the program to its members and to landlords... A number of real estate agencies are now actively involved in supporting and promoting the program and have really helped landlords to understand the program. Once an agency is on board, individual agents learn about Doorway and also get to know participants as they attend inspections and apply for properties. Agents are able to answer questions that landlords may have about the program, and even advocate for people. In several instances, this support has made the difference in a landlord deciding to offer their property to a Doorway participant over other applicants.

**Key components**

As well as building strong relationships with real estate agencies and landlords, the Doorway program makes some other important adaptations to the Housing First model to assist participants to increase their levels of social inclusion. These include:

**Increased choice**

Each person is supported to explore and identify housing preferences and to match these with available resources and properties, so that a person’s ‘sense of what is a desirable and ideal home is incorporated into how that home is formed and shaped’ (Kendrick, 2008). Once they secure a suitable home, a selection of furnishings is provided so they can design their home environment and invite input from family and friends.

The movement towards person-centred services changes providers to continually go further in giving people choice and control, including the power to co-design the services that will best support their needs and recovery goals. In Doorway, each person is involved in the ‘design’ of an integrated support team from a service menu that has both core and flexible elements, including peer support, employment consultants, family services and other health professionals. Assessment, planning and review are all designed to be led by the participant.

**Focus on social inclusion**

Loneliness and social isolation continue to be significant issues for people even on stable housing is achieved (Franklin & Tranter, 2011). Getting involved in employment, education and training is a key marker of success in recovery for many people and directly addresses the social exclusion experienced by people with a mental illness. Doorway will combine housing and tenancy support with a focus on assisting people to connect with friends, neighbours and the ‘interlocking social organisations of people that make up communities’ (David & Baron, 2010).

Natural support networks are the relationships that occur in everyday life, and usually involve family, friends, neighbours, co-workers and casual acquaintances. These relationships tend to be reciprocal and are vital in helping to develop a sense of belonging. Doorway draws on the Circles of Support approach: a social support intervention that provides guidelines and structured interventions in the development of a person’s natural support network. The Circles of Support model has also shown some promise as an adjunct to Supported Employment services in assisting people with psychiatric disabilities to get and keep a job (Spagnolo et al, 2011; Roberts et al, 2010).

**Sustaining tenancy through employment**

People with a mental illness can become trapped in a stressful cycle of debt and poverty, which is affected by and affects their capacity to become successful tenants. Participants will be able to access — when they are ready — appropriate, tailored support to gain employment and to improve their financial situation.

Doorway participants will have access to employment consultants who use the Individual Placement and Support model. IPS has resulted in paid employment for most participants, at a far higher rate than people with a serious mental illness enrolled in mainstream vocational support. A study by Bond & Drake (2008) demonstrated that 43.6 percent of IPS participants worked 20 hours or more per week, compared to 1.4 percent of people who received treatment as usual. Getting a job is a well-established marker of recovery and will increase people’s ability to reduce their rental subsidy, ensuring that tenancies are sustainable when people move on from Doorway.

**Summary**

Housing is understood to be a basic human right, and many services for people with mental illness do work to ensure that people have secure and stable accommodation. In Doorway, the concept of home is supported by the principles of choice, social inclusion and sustainability. Working with people to create both a home and a life means ensuring that each person’s identity, values and preferences are considered in shaping both their living environment and the services and partnerships that support the person.

**References**


Recovery orientation: effective implementation through the use of coaching

Ian Oliver, Manager Prevention & Recovery Care Program Projects
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A coach is more than a problem-solver; he or she is a partner working with the individual to help them to be the best they can be. Crucially, a coach generates an environment in which the person coached is able to feel stretched and challenged in a supportive manner.

When we talk about recovery in the mental health field many of us think of the journeys described by consumers of mental health services. In recovery literature, a number of common themes emerge (Slade, 2009). One is talk of ‘someone who believed in me’ as a central tenet of the recovery journey. This can be translated as someone who carried hope for the individual when they had little or no hope for themselves.

Over the last ten years or so many services worldwide have renamed themselves as ‘recovery orientated’ or ‘recovery focused’ but very few have systematically trained their staff in the latest evidence-based recovery interventions, much less created systemic changes to support this training. The evidence is clear from all industry, including health and welfare, that very little training expenditure is ever translated into practice.

The potential thus exists for the renaming of a service as ‘recovery oriented’ to be seen as merely an expression of political correctness. Indeed it could be argued that this will only reinforce the argument posed by the ‘recovery skeptics’.

How then can workers in recovery orientated services carry hope for people if they have not been given the skills necessary to assist in the journey? Or if training has been provided, but not internalised and made part of the worker’s day-to-day practice?

This paper argues that mental health services can look to other service-based industries for good models for change and innovation, and that coaching in particular holds great promise and purpose.

We suggest that, for a service to be truly recovery orientated, the organisation as a whole must first embrace the concept and practices of recovery (Slade, 2009). Furthermore, this recovery orientation should consist of several parallel processes: the emergence of the service as a newly defined entity; the redefinition by staff members of their role, and the emergence of a preferred identity for consumers.

In conjunction with this, the staff must possess the knowledge, value base, skill set and desire to make recovery a reality. In essence it is not what you call yourself but what you actually do, that will define you in the eyes of others.

Health care innovation

Many authors and researchers speak about innovation in health care, however very little applies directly to mental health service providers. Much of the existing research has focused on improving the delivery of services to clients in large health care settings. Notably Porter and Teinberg (2006) argue strongly that the way to innovate in health care is through the realignment of health care provider’s service delivery with the value it provides to patients. This seems an attractive and rational argument at first glance.

However, one of the challenges the health care sector broadly, and mental health sector specifically, has faced is in seeing itself as different when, in fact, many of the same organisational dynamics exist within other service-based industries. If we accept that mental health service providers respond to the same organisational dynamics as other service types, then there could be much to learn from those non-mental health organisations that have flourished, while sciences such as Positive Organisational Scholarship (Caza & Cameron, 2008) teach much about what works well in generating innovation.

The same techniques that have helped to develop these industries would benefit the health care sector.

We will concentrate in this article upon one of these core techniques: coaching.

Coaching: how to define?

There are many and varied descriptions of coaching. To compound the difficulty in finding a catch-all definition, there are also numerous ‘models’ of coaching (Passmore, 2007).

That said, there are some agreed practices that appear within all definitions and models. It is reasonable therefore to state that, through a process of a structured dialogue, coaching offers the opportunity for an individual and their organisation to pursue their unrealised potential. Furthermore, through the art of effective questioning and reflection, coaches help individuals articulate their current situation clearly, leading to a greater vision of what they would like their future to look like.

A coach is more than a problem-solver; he or she is a partner working with the individual to help them be the best they can be. Crucially, a coach generates an environment in which the person coached is able to feel stretched and challenged in a supportive manner.

As you look at coaching more closely, the parallels with the essence of recovery orientation become apparent. The United Kingdom’s Institute of Psychiatry (2011) talks about coaching as: assuming the person is or will be competent to manage their life; learning to live with mental illness; strengthening the person’s existing relationships; and both participants playing an active part in order to make this work.

The role of coaching

The evidence is overwhelming in wider industry for coaching as the ‘gold standard’ for developing staff and enhancing the uptake of new skill sets. Research has demonstrated benefit in all areas of organisational and individual performance, and led to annual spending on coaching in the United States of now more than $1 billion. Outside the healthcare sector, coaching is rapidly being accepted internationally as a core methodology and significant growth is evident in Australia (Grant & Zackon, 2004). Indeed, Biono-Mathis et al (2008) make the point that organisations (which) are hoping to raise the bar and create high performance cultures are making coaching part of the ‘way they do business’.

There is also mounting evidence that the core elements of a recovery orientation can be best achieved through a coaching dialogue. Mike Slade (2009) says that ‘staff can support recovery by, wherever possible, using coaching skills’ and notes that coaching is a core tenet of innovative work being done in the United Kingdom. In discussing the promotion of recovery in community mental health services, the UK’s Institute of Psychiatry (2011) identifies coaching as ‘a specific interpersonal style which supports recovery’. It has developed its own coaching framework with five core stages: Reflection, Exploration, Agreed Outcomes, Action and Holding to Account.

Despite all this, there is little evidence to suggest that mental health service providers are systematically integrating coaching into their practices, either in Australia or elsewhere.

The Doutta Galla experience

Doutta Galla Community Health (DGCH) is an example of a CM&MH service using coaching methodology to address its aim of becoming truly recovery orientated.

DGCH provides a range of primary health and community services in Melbourne to the Cities of Melbourne and Moonee Valley. Services include allied health, health promotion, medical, and dental health programs. The configuration of its mental health programs is representative of the non-government, not-for-profit sector in Victoria. These include:

• Home-based Outreach
• Prevention and Recovery Care Program (PARC) in partnership with Melbourne Health
• Social Inclusion Programs (formerly called Day Programs)
• Adult Residential Rehabilitation
• Youth Residential Rehabilitation
• Care Coordination & Intensive Home Based Support Initiative.
DGCH has provided mental health programs since its merger with Macaulay Community Support Association in 2000. Like most PDRSS services, the current configuration of programs has evolved extensively since Macaulay was originally established as a small outreach program with three staff in 1987. The evolution can be charted through an amalgam of drivers and imperatives, including innovation, necessity, expansion, mergers, innovation grants, opportunism and growth and in keeping with government policy initiatives at both state and federal levels.

Introduction of a CRM model

In 2010 DGCH introduced the Collaborative Recovery Model (CRM), a strengths-based coaching model, as its overarching service delivery model across all mental health programs. The CRM has been well documented elsewhere and therefore will not be explored at length in this article. But at its heart lies a coaching relationship which aims to generate an environment where the person being coached articulates solutions to their desired goals (Oades et al, 2003). This is not therapy but a process that builds upon strengths and values to generate a meaningful life. In turn this leads to the re-establishment of hopefulness and a preferred identity.

The reasons behind the introduction of CRM were multiple, including the need to:

- formally adopt a recovery orientation
- pursue evidence-based practice
- ensure quality and consistency
- continually improve consumer involvement
- provide staff with the training, support, supervision and tools to perform their role
- embrace contemporary knowledge and directions in mental health (led by both government and consumer).

Central to its introduction at DGCH was the decision to evolve the role of the worker from support giver to recovery coach. It was therefore a major initiative for the service involving extensive consultation and planning with staff and consumers, the training of all mental health staff, and the introduction of formal coaching to support and embed CRM training into everyday practice. The application of skills learnt at training into the workplace is referred to as ‘transfer of training’ (Uppal et al, 2008) amongst its many other benefits, coaching has been proven to significantly improve transfer of training (Deane et al, 2006).

DGCH workers now deliver the CRM directly to consumers of the service. They are, in turn, coached by a team of internal coaches who are supported by an external coach. Plans are in place to develop a small team of lead coaches who will take over this external role.

Results

Recently the organisation conducted a multi-faceted review of the impact of the CRM and coaching programs. This included the use of forums, an online survey, and one-on-one interviews. A number of themes emerged:

1. People spoke of the growth that coaching had brought for them as workers and those they were coaching. The parallel process in action.
2. They also spoke of the ‘aha’ moments within coaching: points where their practice development moved through internal realisations.
3. Most people described developing a deeper understanding of the model (CRM). This is a key driver in ensuring fidelity to an evidence-based model.
4. Significantly enjoying the coaching itself appeared to support the process of engaging with overall framework. Haun Tan has been emphasised as fundamental to effective engagement.

Comments

There are demonstrably clear parallels between the aims of the recovery movement and that of a coaching intervention. Leaders in the recovery movement have identified coaching as a method of enhancing relationships and communication in recovery-oriented services. It is surprising then that the mental health sector has not widely adopted coaching as an organisational development strategy, despite the successful implementation of coaching throughout the broader business sector. We suggest the natural alignment between coaching and recovery provides one methodology for assisting services in becoming truly recovery oriented.

References


Sade P, 2009, ‘100 ways to support recovery: a guide for mental health professionals’, Pathway.org, United Kingdom.

We say that the community sector delivers services on the Government’s behalf so it has an obligation to ensure that we are fully funded to provide these services and supports to the most vulnerable Victorians.

This year saw a landmark ruling on equal pay for the community sector: How did this case begin?

The predominantly female Social and Community Services (SACS) workforce endures, over many decades, an increasing wages gap with those working in comparable industries. This gap, and its link to the gender undervaluation of SACS work, was the catalyst for Australian Services Union’s (ASU) equal pay case. The first case was run in Queensland and, after its success, the decision was made to run a national case, calling for similar salary increases as were achieved in Queensland.

The case began in March 2011 when the ASU, along with other unions, lodged an application for an Equal Remuneration Order under the Fair Work Act 2009. This case was the first of its kind under the Act.

What were Fair Work Australia’s initial findings?

After nearly a year of hearings, site visits and submissions, on May 16, 2011, Fair Work Australia handed down its preliminary decision that community sector workers do not receive equal remuneration for work of equal or comparable value. They also ruled that gender was an important contributor to the wage gap.

Fair Work Australia then called on all interested parties to make further submissions and provide additional evidence to the extent that gender contributed to the wages gap in the sector. From there, there were another 10 months of additional hearings and evidence, including a joint submission from the ASU and Federal Government that agreed on a way forward, taking us to February 2012 when the full decision was handed down by Fair Work Australia.

What was the decision and what does it mean?

It’s not often we get to be part of making history, but we did with the decision which acknowledged the historical undervaluation of the work of the community sector’s predominantly female workforce. This was probably the most exciting part of the decision (apart from the financial benefits for tens of thousands of workers, of course) – the recognition of the role that gender played in inhibiting wages growth in the sector, where about 80 per cent of workers are women.

The decision has, of course, widespread and long-term implications for our sector. As our CEO Cath Smith said to the media on the day: ‘This decision is a turning point for the future of the community sector. From today, when people are thinking about their careers, the community sector will now be seen as a rewarding and fairly paid career option for all Australians.’

What did FWPA order, and is it what was expected/hoped?

Salary rates in the sector, for those who are paid under the Social Community Home Care and Disabilities Services Award
2010 (SCHADS), will increase from between 19-41 per cent (Level 2:19 per cent, Level 3:22 per cent, Level 4:28 per cent, Level 5:33 per cent, Level 6:36 per cent, Level 7:38 per cent, Level 8:41 per cent). On top of this will be 4 per cent loading (paid over the phase-in period), along with annual minimum wage increases.

These are the increases that the Australian Services Union (ASU) and the sector had campaigned for and what we expected (hoped) to be delivered, as they reflect those previously granted to Queensland sector workers. The eight year phase-in period, with nine equal installments, from 1 December 2012 is longer than we had hoped (the ASU and the Commonwealth Government's submissions recommended a six year phase-in) however this timing will hopefully ensure that there is no barrier for funders, both government and non-government, to fully fund the new wage rates.

So is everything done and dusted now – the pay rises will came automatically now?

No, actually now the hard work has begun for the sector.

In Victoria, we have begun working on modeling with government and non-government sources of funding – the Department of Human Services, employer organisations, peak bodies and our members – making sure the sector is prepared for the transition to the Social, Community, Home Care and Disability Services (SCHADS) Industry Award 2010 (commonly known as the Modern Award) on 1 July 2012 and then for the implementation of the fair pay decision on 1 December 2012.

We are also still waiting on the final Equal Remuneration Order (ERO) to be handed down by Fair Work Australia regarding the relationship between the transition to the Modern Award and the methodology being used to calculate the salary increases throughout the implementation period.

Hasn’t both federal and state governments already committed to doing that?

The Commonwealth has but, at the time of publication, Victoria has only committed to funding $200 million over 4 years, pending the finalisation of the case. We will be working closely with the Victorian Government to ensure that the outcomes of the case are fully funded.

The State Government (and other sources of funding to the sector) may argue that they don’t have enough money to fund the increases. We say that the community sector delivers services on the Government’s behalf so it has an obligation to ensure that we are fully funded to provide these services and supports to the most vulnerable Victorians.

We are also pointing out that all our research, including that of the Productivity Commission on the productivity of the not-for-profit sector and research commissioned by VCOSS from Allen’s Consulting Group, has shown that no more efficiencies can be gained from the community sector without cutting into service delivery.

VCOSS’ media release said, ‘The COSS network will be analysing the decision on implementation to ensure it won’t undermine service effectiveness over time.’ What does that mean?

Like with any decision to be implemented over a long period of time, there will be changes in the environment and shifting costs and relative to take into consideration. As a sector we need to ensure that we analyse our work practices and organisational viability to ensure that any salary increases have a positive impact on our workers and our clients.

A lot of other issues have been on hold too, waiting for the decision. Now we can open the door on discussions around funding for the sector, rates for price indexation of services, and building a stronger workforce, particularly looking at the real challenges we face on training, recruitment and retention.

What was it like getting such an outcome after such a long fought campaign?

It was amazing to be part of such an historic win. This couldn’t have happened without the changes to the Fair Work Act enacted by the Rudd and Gillard Governments, the support of the Commonwealth in developing a joint submission with the ASU, the involvement of peak bodies and the sector and, above all, the leadership and determination demonstrated by the ASU and their members. We were up against some pretty strong opponents, including broader industry and employer groups, and there’s still some risk that the decision could be appealed.

We congratulate the ASU and its members for running a successful case over the last two years. VCOSS also wants to thank its members for their long-running support, in particular those that provided additional funding for us to campaign on pay equity.

What’s the next step in advancing the sector’s sustainability?

We are facing a period of big change. In the next 18 months we will transition to the Modern Award, renegotiate rates of price indexation for Victorian Government funded services, see the introduction of a National Charities Regulator, receive the Government’s response to the Protecting Victoria’s Vulnerable Children Inquiry, undergo Victorian and national not-for-profit law reform, and see the commencement of the National Disability Insurance Scheme (amongst an array of other sub-sector reforms), Commonwealth of Australian Government initiatives, etc.

VCOSS will be working with peak bodies and the sector, commissioning research, development sector viability management tools and delivering training, support and resources to ensure that the sector is kept informed and represented on each and all of these issues and initiatives.
National psychosis survey: mapping use of services

Section 1. Overview and findings

The 2010 Survey of High Impact Psychosis (SHIP) is Australia’s second national psychosis survey. The survey covered 1.5 million people aged 18-64 years, approximately 10 per cent per cent of Australians in this age group. A two-phase design was used. In Phase 1, screening for psychosis took place in public specialised mental health services (public inpatient and ambulatory/community mental health services) and non-government organisations supporting people with mental illness. In Phase 2, 1,183 people who were screen-positive for psychosis were randomly selected, stratified by age group (18-34 years; 35-64 years) and interviewed. The data collection included symptomatology, substance use, functioning, service utilisation, medication use, education, employment and housing, as well as a comprehensive assessment of physical health including a physical examination and the collection of fasting blood samples.

Survey participants were asked to identify the most important challenges for them in the coming year. The top three challenges were not health-related. They were financial problems (43 per cent), loneliness and social isolation (37 per cent) and lack of employment (35 per cent).

The one-month treated prevalence of psychosis was 3.5 cases per 1,000 population. The majority (63 per cent per cent) of participants met the World Health Organisation’s International Classification of Diseases (ICD-10) criteria for schizophrenia or schizoaffective disorder and 17.5 per cent met criteria for bipolar affective disorder. Symptoms reported over a 12 month period included: delusions (61.1 per cent), hallucinations (36 per cent), elevated or irritable mood (23.5 per cent), anxiety (60 per cent) and depression (54.5 per cent). The majority (92 per cent) were using psychotropic medication. Polypharmacy was common: 63 per cent were on more than one class of medication and 27 per cent of those on antipsychotics were using two or more.

Half of the sample met criteria for metabolic syndrome, a combination of medical disorders that increases the risk of developing cardiovascular disease and diabetes. Rates for other physical health conditions were markedly higher in people with psychosis compared to the general population. The proportion currently smoking was 66 per cent. Half had a lifetime history of alcohol abuse/dependence and 54 per cent had a lifetime history of illicit drug abuse/dependence. Two-thirds were impaired in their capacity to socialise over the previous year and one-third had impaired ability to care for themselves over the previous four weeks. Educational achievement was low and only 33 per cent had any paid employment in the past year. Nonetheless, regardless of the difficulties facing them, 72 per cent of people with psychosis were very or somewhat satisfied with their level of independence and 77 per cent believed their circumstances would improve over the forthcoming year.

This is the first national epidemiological survey to measure the prevalence of psychosis in non-government organisations funded to support people with a mental illness and to look at the characteristics of people with severe mental illness using this sector. We present the data collected for two groups of users of non-government services:

1. People solely using non-government organisations in the census month (March 2010) and not receiving public specialised mental health services over the same period. This smaller group is described in Section 2 below.

2. People using non-government organisations in a 12-month period either solely or in conjunction with public specialised mental health services. This larger group is described in Section 3.

The rest of this report summarises mental health service provision in the non-government sector and is extracted from the main report of the survey (Morgan et al, 2011). The full report may be downloaded at: www.health.gov.au/mentalhealth.

Section 2. People solely in contact with non-government mental health services in the census month

One-month prevalence estimate

The estimated national one-month prevalence of ICD-10 psychotic disorders in people solely receiving mental health services through non-government organisations was 0.4 cases per 1,000 population aged 18-64 years, a total number of 6,204 persons. The rate was higher for males than females, at 0.6 and 0.3 cases per 1,000 population respectively.

Key characteristics

One in ten (11 per cent) participants was only in contact with non-government organisations funded to support people with a mental illness in the census month and not in contact with public specialised mental health services over the same period.

These participants differed from those using public specialised mental health services on a few key variables. They were more likely to be older, with three quarters (74 per cent) aged 35-64 years (compared to 60 per cent). They were less likely to be employed, either currently or in the past year.

Although they were less likely to have a diagnosis of schizophrenia or schizoaffective disorder, people receiving mental health services solely through non-government organisations were a more disabled group with markedly poorer functioning.

Despite only using non-government mental health services in the census month, many had used other health services either in the 11 months prior to census or between census and interview. However, they were much less likely to have used public health services for mental health treatment and a little more likely to have used public health services for physical health reasons over the past year (Table 1). They were also a little more likely to use general practitioner services.
This is the first national epidemiological survey to measure the prevalence of psychosis in non-government organisations funded to support people with a mental illness and to look at the characteristics of people with severe mental illness using this sector.

Section 3. People using non-government mental health services in the past year

Many participants were in contact with both non-government and the public specialised mental health services, with one in three (30 per cent) participants overall using mental health services provided by the non-government sector in the past year. This section describes the types of programs and kind of support that these participants were receiving from these agencies.

Rehabilitation programs

Just over one third (36.5 per cent) of people had participated in community rehabilitation or day programs within public mental health services and/or non-government organisations in the past year (Table 2). More participants were involved in rehabilitation programs in the non-government sector (22 per cent) than in the public mental health sector (14.5 per cent).

The majority of participants using these programs found the program useful, with 87.5 per cent of those using public specialised mental health services and 90.0 per cent using non-government community rehabilitation programs reporting that they were somewhat or very satisfied.

The percentage with an individual rehabilitation or recovery plan was 29 per cent.

Table 2. Community rehabilitation programs in past year by sector

<table>
<thead>
<tr>
<th>Proportion (%)</th>
<th>Public specialised mental health services</th>
<th>Non-government organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended community rehabilitation program*</td>
<td>14.5</td>
<td>22.4</td>
</tr>
<tr>
<td>Type of program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>13.6</td>
<td>46.5</td>
</tr>
<tr>
<td>Individual</td>
<td>72.0</td>
<td>29.1</td>
</tr>
<tr>
<td>Combination of both</td>
<td>13.3</td>
<td>24.4</td>
</tr>
<tr>
<td>Not known</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Usefulness of program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very helpful</td>
<td>54.9</td>
<td>62.6</td>
</tr>
<tr>
<td>Somewhat helpful</td>
<td>32.6</td>
<td>27.4</td>
</tr>
</tbody>
</table>

* Some participants used rehabilitation programs in both sectors
Group-based rehabilitation programs
Non-government organisations are key providers of rehabilitation programs to people with psychotic illnesses, with one quarter (22 per cent) of all participants attending non-government-run programs in this sector and 90 per cent of them reporting that the programs were very or somewhat helpful (Table 2).

The most commonly attended programs were independent daily living skill programs (33 per cent), healthy living and fitness programs (30 per cent) and creative activities (28 per cent). These were followed by programs targeting anxiety and stress (23 per cent), communication and social skills (22 per cent), mood management (17 per cent) and symptom management (13 per cent). Smaller proportions of people had attended alcohol and drug management programs (7.5 per cent) and anti-smoking programs (3.5 per cent) (Figure 1).

One-to-one support
As well as running group-based rehabilitation programs, non-government organisations also provided one-to-one support and assistance. Two-thirds of participants supported by non-government organisations (69 per cent) had received counselling or emotional support, while many had received help to access other services, including community services (45 per cent) and mental health services (37 per cent), just over two-thirds had received information on mental illness (44 per cent) or recovery planning (41 per cent). One third had been given practical assistance in the form of home help (32 per cent) and subsidised meals (32 per cent), and one quarter had received housing assistance (25 per cent). Almost one quarter had received vocational or skills training (23 per cent) or help with paid or unpaid employment (22 per cent) (Figure 2).

Case management and home visits
Seven out of ten participants reported having a case manager in the past year: 62 per cent of the total sample had a case manager provided by public specialised mental health services and 20 per cent had one provided by a non-government organisation, with 13 per cent having one provided by each sector at some stage over the past year (Table 3). Satisfaction with case management from both sectors was high, with 85 per cent of participants with public specialised mental health service case managers and 89 per cent of those with non-government case managers being very or somewhat satisfied.

Three-quarters of participants reported being happy with the frequency of contact with their case manager. Most of the remainder would have preferred more contact: 13.5 per cent of people with a case manager provided by public specialised mental health services and 16 per cent of people with one provided by a non-government organisation.

Table 3. Case management by sector if case managed in past year

<table>
<thead>
<tr>
<th></th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case manager*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Public mental health services</td>
</tr>
<tr>
<td>For those with a case manager</td>
<td>61.6</td>
</tr>
<tr>
<td>Contact with case manager is as often as preferred</td>
<td></td>
</tr>
<tr>
<td>Frequency of contact</td>
<td>76.5</td>
</tr>
<tr>
<td>• Once a week or more</td>
<td>28.1</td>
</tr>
<tr>
<td>• Less than once a week, but at least once every 4 weeks</td>
<td>54.4</td>
</tr>
<tr>
<td>Satisfaction with case manager</td>
<td></td>
</tr>
<tr>
<td>• Very satisfied</td>
<td>62.2</td>
</tr>
<tr>
<td>• Somewhat satisfied</td>
<td>22.8</td>
</tr>
</tbody>
</table>
| *Some participants had case managers in both sectors over the past year

Around half (53 per cent) had had one or more home visits in the past year by someone from a non-government organisation.
Personal Helpers and Mentors Services

The Personal Helpers and Mentors Services (PHaMS) is an Australian Government initiative delivered through non-government organisations to support people with a severe mental illness to manage their daily activities and live independently in the community with coordinated, integrated access to community services. The first demonstration sites were funded in 2007.

In all, 12 per cent of participants had a personal helper over the past year. Many had used the service for a long time. The majority of those using the service (60 per cent) had had a personal helper for a year or longer, and over a quarter (28 per cent) had had one for two years or more.

Two thirds (64 per cent) of those participants with a personal helper received support to manage daily activities. Personal helpers also assisted by referring participants to other services (49 per cent), accompanying participants to appointments (45 per cent), and acting as an advocate (45 per cent). Services had also provided support with physical activities to one-third of participants (34 per cent) and support to one fifth of participants’ families and other carers (21 per cent). See Table 4.

Table 4. Type of support provided by personal helper in past year

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Proportion of those with a personal helper (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided participant with support to manage daily activities</td>
<td>64.0</td>
</tr>
<tr>
<td>Referred participant to other relevant services</td>
<td>49.3</td>
</tr>
<tr>
<td>Accompanied participant to appointments</td>
<td>45.3</td>
</tr>
<tr>
<td>Acted as an advocate</td>
<td>45.3</td>
</tr>
<tr>
<td>Provided support with physical activities</td>
<td>34.2</td>
</tr>
<tr>
<td>Supported participant’s family or carer</td>
<td>21.3</td>
</tr>
<tr>
<td><strong>Total respondents</strong></td>
<td><strong>225</strong></td>
</tr>
</tbody>
</table>

Section 4. Conclusion

Survey participants were asked to identify the most important challenges for them in the coming year. The top three challenges were not health-related. They were financial problems (43 per cent), loneliness and social isolation (37 per cent) and lack of employment (35 per cent). Health-related issues were ranked next, with 27 per cent naming physical health issues and 26 per cent naming the uncontrolled symptoms of mental illness. Housing was ranked sixth, at 18 per cent. A major undertaking of the 2010 Survey of High Impact Psychosis (SHIP) was to collect key and, in some cases, unique data on these challenges and many other aspects of the lives of people with severe mental illness, including their use of services provided by non-government organisations. It is hoped that the data collected will inform policy change and service provision to the benefit of people living with psychosis, their family, carers and the services supporting them.

Reference

Prahran Mission UnitingCare (formerly Prahran Methodist Mission, then later Prahran City Mission) was established in 1946 when the premises at 211 Chapel Street Prahran were purchased for 30,000 pounds. In 1977 the Mission became part of the Nepean Presbytery of the Uniting Church in Australia. In 1982, the first day program for people with a psychiatric disability in Victoria was established with funding from the Commonwealth - one of only two organisations at the time funded for work in this area in Victoria.

Prahran Mission is committed to the well-being of the community through its mental health, aged care, employment, social firms, housing and residential services and community development activities. It provides high quality social and professional community services and challenges unjust social and economic structures. Prahran Mission serves, assists the empowerment of, and advocates alongside people who have a psychiatric disability, older people, youth, the homeless, people from non-English speaking backgrounds, diverse communities and other economically and socially disadvantaged individuals and groups.

Our mission is to partner with those who have or have had a mental illness or experience extreme social and economic disadvantage in order to facilitate a full and meaningful life. Prahran Mission achieves this through the provision of services that are grounded in our values and by effecting beneficial social change that creates opportunities for meaningful participation in society.

During 2010/11 more than 3,500 people were helped by Prahran Mission. The Mission’s profile and reputation was largely built around providing a social outlet and food, clothing and material aid to the financially and socially disadvantaged across Melbourne’s Inner South-East region. The reality now however is that approximately 90% of expenditure and staff time is spent caring for people with varying degrees of mental illness. Over 600 consumers access the Mission’s services every week.

Prahran Mission’s services extend across the Local Government Areas (LGAs) of the Cities of Stonnington, Glen Eira, Port Phillip, Monash, Boorandara, Kingston, Greater Dandenong, Yarra and Bayside.

The recent redevelopment of the Chapel Street site has allowed a growth in services such as training and job placement as well as additional social support programs and space for emergency services for people living with mental illness to increase the capacity to feed and clothe, provide financial relief and assist in finding a home.

Prahran Mission has six discrete suites of client services programs which are:

- Support (Motors’ Support Program, Prahran Bayside and Monash; Inner South Outreach; Killara Aged PDRSS; Day Rehabilitation (Open House, Second Story, Emergency Relief, Stables Art Studio, Voices Vic and ConnectEd Employment, Education & Training (JodSpply Personnel Employment Service).
- Aged Care (Community Aged Care Packages)
- Scotsdale Residual Service and Haven South Yarra (24 hour Residential based psycho-social rehabilitation) Retail Operations (Opportunity Shops, Restaurant, Catering, Café, Volunteer Support and Hospitality and Retail Training).

One of our most important programs in the PDRSS Home Based Outreach area is the Mother Support program. This program works with women who are affected by mental illness, and who have children living in their care. This program provides a psycho-social rehabilitation program to women who have an enduring mental illness. It is a goal oriented program which assist women to achieve important outcomes in areas such as parenting, housing, physical wellbeing and social connections.

Another important focus of the organisation has been to provide support to people in the Open Employment area. Through JodSpply Personnel, a federally funded Employment Program, we have been able to assist over 200 people a year for the past 18 years. The focus on employment participation in all our strength based mental health programs has become increasingly important.

VICSERV Conference Presentation:

Prahran Mission is looking to present and showcase a number of areas in both the VICSERV conference this year and the MHS conference later in the year. The Haven South Yarra Residential Rehabilitation program staff will present the benefits of working alongside carers in this innovative model. VOICES VIC, part of Day Rehabilitation, will be presenting on the enormous benefits and growth when true participation is nurtured and encouraged within an organisation. As a partner in the Inner South East Mental Health Alliance, Prahran Mission will be presenting with others on the art and practice of collaboration.

New Developments:

In the early days I think our sector was quite significant in providing an alternative to the medically based mental health services and in fact it was this "volunteer participation" notion that many people were attracted to. I believe that now is the perfect time for some new thinking around the way service is provided. The increased recognition by participants and government across Australia of the value of work by the community managed mental health sector will lead to further opportunities for partnerships between clinical and community managed services.

It is indeed exciting to see participants finding their voice across the sector and having a lot more say in planning, developing and running of programs. It has becoming easier to identify the building blocks of what constitutes a good program; empowerment; assumption that the user is in control; dignity; meaningful evaluation and values that are based on the belief that recovery is possible.

The areas I see as developing rapidly in the next few years will be that community managed agencies will be increasingly looking at accountability and how they can measure an effective outcome, both for participants and for funding bodies. The ability for agencies to accurately fully cost the work they do in order to be effective and use the funding in the most efficient manner will become more important as block funding changes. The importance of meaningful employment and physical health will increasingly be recognised as an important aid to recovery. The role of families and carers should be utilised more, where appropriate, to assist in the development of recovery plans.

Organisations will need to be innovative around workforce training, retention and appropriate recognition as the sector grows and requirements become more stringent.

One thing in our work never changes – it is a deeply personal and challenging relationship between the organisation, worker and participant.

Finally, as participants often point out, recovery is a deeply personal and emotional process you do yourself. In reality services are just here to assist, when needed. It has been my immense pleasure to be able to work in an area where one is constantly inspired by the courage and determination of people.

About the author

Celebrating 21 years in the Community Managed Mental Health Sector this year, Mark Smith has been General Manager of Services at Prahran Mission UnitingCare for almost 9 years. He previously spent 18 months as a Senior Project Officer in the Mental Health Branch in the Department of Health working on Quality Improvement Projects and before that 12 years in Management in PDRSS Home Based Outreach and Employment programs. Mark has been a director on the VICSERV Board of governance for the past six years.

Mark Smith, General Manager Services
EXPRESSION SESSION

The following artworks in this edition’s Expression session are by participants in North Yarra Community Health’s art programs. North Yarra will be presenting further examples of creativity at the Reframing mental health conference.
Autumn 2012

Psychiatric Disability Services of Victoria (VICSERV)

Callum McFarlane

Expression Session
Book review
Understanding troubled minds: a guide to mental illness and its treatment (full revised second edition)

Professor Sidney Bloch, Melbourne University Press, 2011

Mental illness is troubling; troubling for the person who has it and troubling for their loved ones. One in five people will have a mental illness in any twelve month period and nearly half will experience it during their lifetime. Will power, love and empathy are seldom enough to make things better. When someone’s thoughts are disturbed and disturbing or their behaviour is bizarrely out of character, few amongst us know what to do. So begins the search for answers which usually starts with seeking professional advice from a GP or mental health practitioner.

Some people also have late night sessions with ‘Dr Google’. There are excellent websites that provide fact sheets and information about where to get help. Reading more widely can be helpful during the journey from diagnosis to recovery and beyond. Many books have been written about specific illnesses, about living with mental illness and about working with people affected by mental illness. A recent release is Understanding troubled minds which is a practical guide to mental illness and its treatment written by Emeritus Professor Sidney Bloch from Melbourne University.

The book begins with a short chapter on the history of psychiatry which highlights the significant advances that have been made in the last fifty years by the scientific community and the consumer movement. A sense of hope and optimism runs throughout the book. The liberal use of brief case studies, insights and images from artists and writers reveal the complexity of human nature. In chapter two: Making sense of a life, the author considers the life of the artist Vincent van Gogh using the twin perspectives of understanding and explanation. The meaning behind a seemingly dear-cut case of mental illness is presented in the broad context of family dynamics, cultural mores and a particular historical moment in time. Professor Bloch uses the life of this famously troubled individual to demonstrate that understanding the impact of an illness on a person and their family is the key to a successful therapeutic alliance.

The book largely consists of chapters describing the workings of the mind and specific disorders and their treatment. There is a section on children and adolescents, one on women and another on the elderly. The book does not focus on the social determinants of mental health. Nor does it acknowledge the role of the community managed mental health service system in working with people to assist their recovery and increase their social inclusion. The concluding chapter contains a very interesting discussion on the ethical dimensions of the practice of psychiatry. Professor Bloch describes the many different ethical challenges encountered by psychiatrists. These include the ethics of making a diagnosis and of voluntary and involuntary treatment. A framework to deal with ethical challenges is presented and is based on principiplism and care ethics.

Understanding troubled minds is very readable, informative and thought provoking. I imagine it would be particularly useful for people recovering from, or who have recovered from mental illness and who might wish to spend some time reflecting on how it was to have a troubled mind.

Reviewed by
Wendy Smith
Policy and Research Manager, newparadigm editor VICSERV
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.

Our Mission

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 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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