



newparadigm

TOWARDS RECOVERY –
SPECIAL POST-CONFERENCE EDITION

THE AUSTRALIAN JOURNAL ON
PSYCHOSOCIAL REHABILITATION

Winter
2016



Psychiatry
of Victoria (V)

VICSERV'S MENTAL HEALTH CONFERENCE

#TowardsRecovery

19 – 20 MAY 2016

HOPE | INNOVATION | CO-DESIGN

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IT STARTS WITH
people at the
BEGINNING
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process, where you find
your own purpose
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Respect those who work
with/under & support
you. They deserve a thumbs-up
too every one in a while.
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TUNNEL
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MESSAGE
of
HOPE
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newparadigm

is published by

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Shane Bell Photography

ISSN: 1328-9195

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 - » the author(s) name
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EDITORIAL

Welcome to the Winter
2016 edition of *newparadigm*.



Debra Parnell is Manager of Policy and Communications at VICSERV

This edition is a Special Conference Edition following the highly successful VICSERV Conference *Towards Recovery – Hope Innovation Co-design* in May 2016.

The VICSERV Conference provides the opportunity to showcase the latest research and share best practice, discuss current developments and trends, and consider the future of mental health services within the context of an ever changing environment. This edition presents some of the highlights of the VICSERV 2016 Conference *Towards Recovery*.

The conference featured a rich and diverse program of speakers and presentations, with challenging and thought provoking key note speakers – Dr Simon Duffy and Prof Mark Salzer – who both gave a great start to each of the two days of the conference.

We are pleased to open this edition of *newparadigm* with articles based on the presentations by both these speakers:

- **Simon Duffy**, the founder and Director of the Centre for Welfare Reform in the UK, challenges Australian mental health community organisations to renew their purpose of being part of the community, not a service for the community. He draws a future in which a positive and exciting path is opening up to community mental health services in Australia today.
- **Mark Salzer**, Professor and Chair of Rehabilitation Sciences at Temple University in the United States, focuses on community inclusion, and the barriers to community participation for people with mental illness. He argues that while it has been a longstanding concept in the disability, it is a relatively new concept in mental health, and therefore, it is not surprising that we have much to learn about the individual needs and environmental barriers that are associated with meaningful community participation, and much to learn about the types of interventions and strategies that are needed to make full inclusion possible.

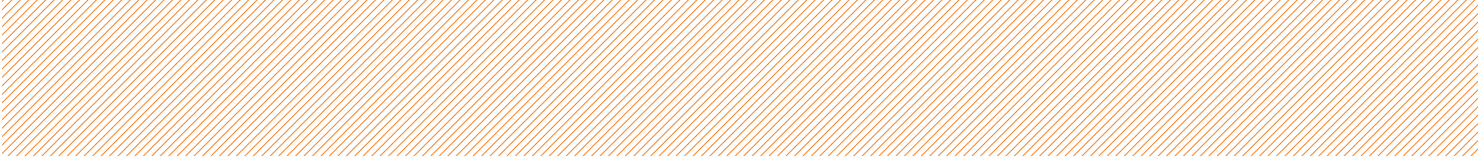
We have drawn on presentations for this special edition of *newparadigm*, that reflect the conference themes:

- Hope and recovery
- Innovation
- Co-design
- Peer-led
- Transformation
- Empowerment/rights

Rights, co-design and coproduction were key themes that were discussed at the conference, and are reflected in the selection of papers for this edition.

Liz Carr, Senior Advocate with the new Independent Mental Health Advocacy service, provides an overview of the service which was established as a key strategy to support people to be involved in the treatment decisions made about them. The introduction of Victorian Mental Health Act 2014 has signalled a shift in mental health service provision towards more recovery-oriented clinical services, and involvement of the person receiving treatment in the decisions that affect them, to the greatest extent possible. IMHA is a powerful example of how the rights of people, autonomy and independence are taking a more central place in the mental health service system.

Following on from this **Cath Roper**, Consumer Academic at the School of Psychiatric Nursing, Melbourne University, discusses coproduction – what it is and what it isn't – and the important role it can have in moving from 'consumer participation' to leadership for people with lived experience, and the transformative potential it holds for identifying problems and implementing solutions.



Peter McKenzie, Carer Academic and Family Practice Consultant, and Clinical Family Therapist at the Bouverie Centre, introduces the practice of *Triologue*, a three-way conversation method, which strongly connects with the notion of co-design. This model brings together consumers, families and practitioners in a way that enables acknowledgement, sharing and exploration of the different voices and perspective.

Providing a perspective from outside Australia is **Marion Blake**, CEO of Platform Trust New Zealand, a collaboration of community organisations that provide services to individuals, families and communities where mental health and addictions are an issue. She discusses Platform Trust's approach to the need to put social change at the centre of the agenda and to do things differently to transform the current health and social support system, by embracing 'disruption innovation'.

Innovation and doing things differently were strong themes at the conference. Hand in hand with this, the implementation and development of the National Disability Scheme (NDIS), and what it will offer people with psychiatric disabilities, featured in many presentations, including:

- The ACT Trial Site is the only whole-of-jurisdiction, whole-of-population trial of the Scheme. **Simon Viereck**, EO at Mental Health Community Coalition, ACT, discusses the experience of the NDIS implementation, and the lessons learnt, from this unique perspective.
- **Rachel Scott**, Program Manager for Mental Health Community Support Services at cohealth, follows this discussion with how

co-health has spent the last few years testing new approaches to the design of their activities, and the method of delivery, and the positives and challenges that have been identified through this process.

Peer work was also a strong theme at the conference, and as one would expect, demonstrates how people with lived experience are leading and building innovative responses to the changing mental health support and treatment systems. We have selected the presentation by **Cassy Nunan**, Consultant on Consumer Advocacy and Leadership at Wellways, as one example of this area of innovation and development. She discusses the emergence of peer hubs or networks across Victoria, with peer workers from four regions describing the functions and outcomes of the peer hubs they are involved in.

This edition of *newparadigm*, can unfortunately bring only a small sample of the rich and diverse thinking, perspectives and developments that were showcased at the conference. If you want more after reading this brief taste of the conference, presentations and abstracts are available on the VICSERV website – www.vicserv.org.au

TOWARDS RECOVERY

Hope, innovation
and co-design

Thinking Big



Kim Koop is CEO of VICSERV

The VICSERV 2016 conference reinforced what we already know – that our members are deeply committed to great outcomes for people affected by mental illness in their communities.

While the issue of service reform has dominated our conversations over the last three years, preparing for and participating in our biennial conference returned our focus to core purposes and helped us to think big on behalf of the individuals and communities we support.

The introduction of the National Disability Insurance Scheme has been, and will continue to be, the focus of much of thinking and planning. Uncertainty around how this program will support people with psychosocial disability has caused great concern. As we draw closer to the full scheme roll-out the workload for all stakeholders has risen dramatically as organisations prepare for a new service environment and new service offerings.

Conferences provide a unique environment, a melting pot of people, perspectives and ideas. They allow us to think through and beyond our immediate concerns. The 2016 VICSERV conference fulfilled this brief by bringing together academics, philosophers, practitioners, policy makers, consumers, participants, families and carers – a wide range of stakeholders.

This year's conference provided us all with a valuable opportunity to stop and reflect on broader issues. To reflect on our shared vision, mission and values; to consider our shared commitment to individuals, families and communities affected by mental illness; and recommit to bringing about a society where people affected by mental illness are full citizens and are actively included in the life of our community.

Many people and organisations play a part in this vision by supporting the health and wellbeing of those affected, working against discrimination and by supporting social and economic participation.

The conference demonstrated the high level of knowledge, skill and experience contained within community organisations and presentations showcased the breadth of services available to our community.

It is clear that while governments are instituting massive changes in public policy from the top, communities are also making changes at the grassroots level, with new social entrepreneurs emerging to fill the gaps between government policies. New services that meet the needs of local communities or community of interest will continue to emerge at the same time that many established organisations are becoming larger.

In this environment several questions remain on the table including:

- How we can move to an iterative process of co-design and co-production that includes all parties – funder, participant/ consumer, community organisation/support services?
- How we can move services up stream to prevent the institutionalisation of service offerings?
- How do community organisations remain focussed on their core vision and mission while adapting to the massive changes in the environment?
- What workforce will we need to ensure high quality, safe and effective supports?

The current challenge, for VICSERV and its stakeholders, is to adapt to multiple changes ahead and to do this with a clear line of sight toward the quality and effectiveness of the services we provide. I have no doubt that the way to do this is by continuing our tradition of collaboration.

VICSERV has represented and worked to build the capacity of its members since 1986. We have trained thousands of workers in that time and produced countless discussion papers and policy documents. In this our thirtieth year, we were delighted to receive the Office of the Public Advocate award (2016). What an honour.

The Public Advocate, Collen Pearce, humbled the current VICSERV staff and Board when she had the audience on their feet delivering a standing ovation. Colleen knows just how deep and wide the connection to VICSERV is after so many years of collaborative work. It is our privilege to carry forward the legacy of so many.

Citizenship and mental health



Dr Simon Duffy is the founder and Director of the Centre for Welfare Reform in Sheffield in the United Kingdom

The welfare state, and the services developed under its auspices, are a vital social development. Without the welfare state, modern industrial society would sink back into an era of insecurity, inequality and injustice. This would lead, as it has done before, to fear, war and terror. The welfare state is a good thing and it must be protected at all costs.

Yet it would be dangerous to assume that the design of the welfare state is ideal. Indeed, given the legacy of the 19th and 20th centuries, it would be amazing if our first efforts to develop the welfare state were perfect. Why would we be suddenly endowed with the wisdom necessary to ensure that the design, funding and ongoing management of the welfare state was all it should be?

In fact my contention is that the current welfare system often tries to solve the wrong problems in the wrong way. Too often we respond to social problems with money, power and new forms of service. Too rarely do we try to understand the real source of our problems or design solutions that are truly effective.

Mental health is a good example of this kind of dysfunction. Modern mental health services have emerged from the dark period of stigma and institutionalisation that swallowed so many people with mental health problems. Yet progress away from institutional services is still very slow and today we see a vast empire of services, in which institutional and hospital based services are still dominant. While it may be natural to think that, if mental illness is the problem, then mental health services are the solution, this is a fallacy. This is clear from the international evidence:

"These findings [better long-term outcomes for schizophrenia in developing countries] still generate some professional contention and disbelief, as they challenge outdated assumptions that generally people do not recover from schizophrenia and that outcomes for western treatments and rehabilitation must be superior. However, these results have proven to be remarkably robust, on the basis of international replications and 15-25 year follow-up studies.

Explanations for this phenomenon are still at the hypothesis level, but include: (1) greater inclusion or retained social integration in the community in developing countries, so that the person retains a role or status in the society; (2) involvement in traditional healing rituals, reaffirming community inclusion and solidarity; (3) availability of a valued work role that can be adapted to a lower level of functioning; (4) availability of an extended kinship or communal network, so that family tension and burden are diffused, and there is often less negatively 'expressed emotion' in the family." (Rosen, 2006)

This research suggests that there is actually a negative correlation between mental health services and mental health. Now this does not mean that mental health services cause mental illness. The causes of mental illness are complex and disputed; it is probably the nature of society as a whole that offers the best explanation for why rates of recovery are better in developing countries.

In a sense, it may be that mental health services are a side effect of deeper social and community problems. For instance, it is clear from many studies that being black in the United Kingdom is very bad for your mental health (McKenzie, 2007). This is also associated with higher levels of imprisonment:

"Mentally disordered black males in England and Wales are six times as likely to be detained in secure forensic psychiatry services as white men." (Coid et al., 2002).

So it seems that racism, operating at many different levels, is likely to be one cause of mental illness and of many other social problems. Yet addressing this issue is complex and will often lead to a focus on the symptoms of the problem, not the real problem.

We also know that rates of mental illness correlate with income inequality (Wilkinson & Pickett, 2010). It is likely that fear, economic insecurity and a sense of being devalued are all contributory factors. So it seems that social injustice is a cause of mental illness. Certainly in the UK, we also know that Government policy to increase employment rates is actually increasing mental illness and suicides:

"In total, across England as a whole, the WCA [Work Capability Assessment] disability reassessment process during this period [2010-13] was associated with an additional 590 suicides (95% CI 220 to 950), 279,000 additional cases of self-reported mental health problems (95% CI 57,000 to 500,000) and the prescribing of an additional 725,000 antidepressant items (95% CI 406,000 to 1,045,000)." (Barr et al., 2015)

Some academics have even argued that mental health professionals are themselves being compromised by their involvement in government-led programs that damage mental health (Friedli & Stearn, 2015). A recent report suggests that academic standards are also being compromised in order to support damaging health interventions (Faulkner, 2016).

Shifting the focus upstream

All of this suggests, if we genuinely care about mental health, that we should focus our attention on much more than funding for community mental health services. Instead we need to take a bigger view of the problem in order to address its fundamental causes. But this is so hard to achieve.

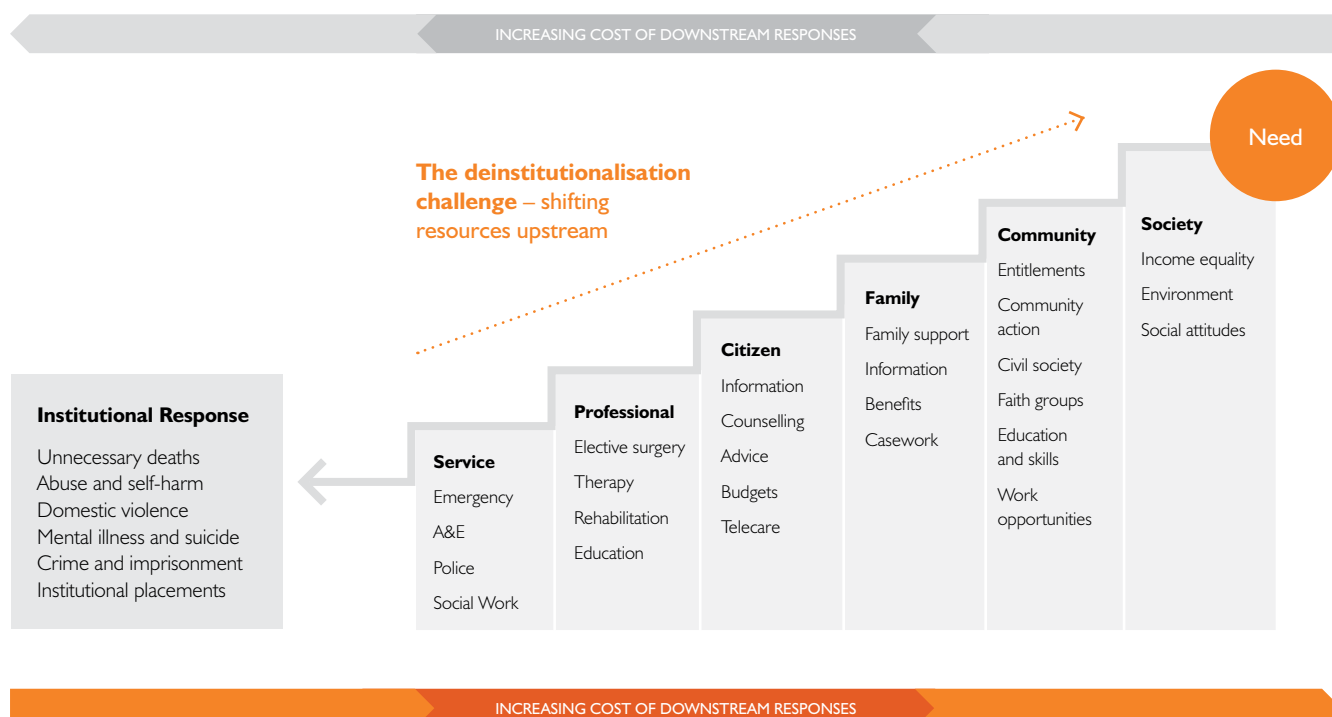
One helpful metaphor is the idea of heading upstream (Meyer, 2008). Imagine a group going out for a walk and then seeing a baby in the river. They will jump in to save the baby. But then they see more babies in the river. At this point one of the group gets out of the river and starts heading upstream. Naturally someone shouts, "Where are you going? We've got babies to save!" But they reply, "I'm heading upstream to see who's throwing babies in the river."

The point here is that even when we know that our downstream solutions are less effective and more costly than upstream solutions, once these solutions have been adopted they become normal. So it becomes very difficult to move attention and resources upstream to solve them more effectively. In fact those who demand we move upstream can appear as trouble-makers or heretics.

Figure 1 outlines the complexity of our current situation. We are committed to our downstream solutions and the further downstream we go then the worse our problems become and the more ineffective and dangerous are our available solutions. Ultimately we pay the price of our failure to solve problems upstream in higher rates of illness, institutionalisation, abuse and death.

Shifting attention upstream seems difficult. Addressing problems of income inequality or social injustice may feel 'beyond our pay grade' and so we leave these matters to politicians or activists. We settle for doing the best we can within our current roles. However, I think we can do better than this, particularly if we recognise that this challenge does not involve one simple shift. Instead there are range of practical possibilities available to move upstream.

Figure 1: The Upstream Challenge



Ultimately we pay the price of our failure to solve problems upstream in higher rates of illness, institutionalisation, abuse and death.

Potential and risks of the NDIS

In the Australian context, the most obvious opportunity to do so is the development of the National Disability Insurance Scheme (NDIS). Effectively this shift to self-directed support is a great opportunity to move resources from services to citizens. In turn this will lead to the development of new and effective forms of support, developed in partnership with people and families themselves (Duffy, 2013a).

In fact, while mental health systems have been slow to welcome self-directed support, the evidence suggests that it is here where we will see some of the greatest outcome improvements (Glendinning et al., 2008). No other group seems to benefit as much from being able to set their own goals, agree on supports that make sense in their own life and better participate in community life. The whole process of self-directed support seems to be a natural fit for increased mental well-being (Alakeson & Duffy, 2011).

The second area where we can see significant outcome improvements is when we shift our attention from the individual approach towards family, peers or community. There are a whole range of fascinating developments which offer us much better patterns for mental health services. Here are just a few examples.

One approach is simply to start with neighbourhoods – to focus on helping communities to address their own needs and well-being. The *C2 community connecting process*, first developed by Hazel Stuteley, is one very effective model which led to a 77 per cent reduction in postnatal depression, plus a wide range of other outcome improvements that would support better mental health (Gillespie, 2011).

Local Area Coordination, originally an Australian innovation, is now being used in England to support people with many different needs, including mental health needs, to avoid using health and social care services (Broad, 2015). This model involves embedding a trained

worker within a neighbourhood to build relationships, spot problems and help people solve their own problems in partnership with community associations.

WomenCentre, based in Halifax, leads work to help women in extreme and complex need to get their lives back on track. The work involves a partnership between trained professionals, women in need, and women volunteers who have been through crisis and come out the other side. The outcome improvements and efficiencies of this process are significant. *WomenCentre* offers a systemic and empowering model of support that is rooted in the local community (Duffy & Hyde, 2011).

Another inspiring model of support is provided by *PFG Doncaster*. This organisation was formed by a group of people with mental health problems who came together to challenge the local mental health system. They wanted personal budgets they could control, rather than the services on offer (Duffy, 2012). However, in the process of fighting for this right, they learned that they themselves, working together, were the best form of support possible. Today the group has taken root in one part of Doncaster and has started to support the whole community by developing a whole range of social activities. They also now support the development of other groups in the region.

These examples suggest that the way we think about the role of community mental health services can move in an upstream direction. Recently the welfare state has tended to push mental health services into being contractually defined and regulated service providers. However, if we move upstream, such organisations can become part of solutions that are rooted in citizenship, family or community. Services can become part of the community, not a service for the community. They can tap into the power of the peer, the love of families and the commitment of fellow citizens. They do not need to fear accountability to and partnership with people themselves. This is the positive and exciting path opening up to community mental health services in Australia today.

Recently the welfare state has tended to push mental health services into being contractually defined and regulated service providers. However, if we move upstream, such organisations can become part of solutions that are rooted in citizenship, family or community.

But there will also be major challenges. As economic insecurity grows so it is natural to resist change. In this respect I think the prevalent language of 'choice' and 'consumerism' is not a helpful paradigm, even if the idea of being a 'consumer' seems to be an advance on being a 'patient'. Ultimately real progress comes when we start to think in terms of our citizenship. The power we need is not choice, but *control*; for it is with control that we can be truly creative – constructing solutions that really meet our needs (see Figure 2).

This is not just true for those of us who have a mental health problem, it is also true for people who have professional roles, who run services or who work in the system. It is when we start to think of ourselves as citizens first that we can also start to address our real problems. This is also how our work takes on true meaning and value.

Ultimately the big upstream problems of inequality, prejudice and oppression can only be resolved by a society that takes its destiny into its own hands. It is only when we wake up to our citizenship, to our responsibility for our own communities, that we can begin to address these toxic problems (Duffy, 2016). This will take leadership, mobilisation and the development of a positive model of social change.

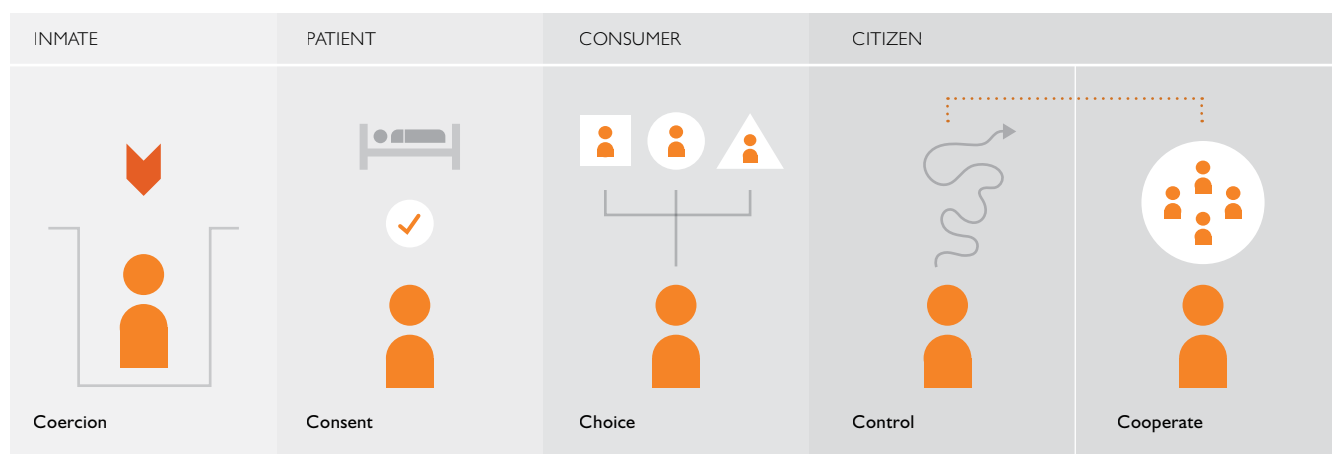
But Australia has already seen sign of what this leadership looks like. The commitment to the NDIS is the world's first serious effort to properly meet the human rights of all citizens with disabilities. It grew out of a partnership of people, families and professionals, who effectively lobbied government and engaged with the wider Australian public. This is one of the most encouraging international developments today.

Inevitably there will be problems with such a big system change (Duffy, 2013b). At first the system may be too bureaucratic and clumsy. But as long as people, families and professionals continue to challenge themselves to keep improving the system then these problems can be addressed. The biggest risk for the NDIS is that people treat the system as if it were a fragile work of art that cannot be touched. The NDIS is a social and economic system created by Australians; critique, challenge and creativity will be essential to ensure that it becomes the best system possible.

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Figure 2: Different modes of power



Making community inclusion a reality: a plan of action



Mark S. Salzer Ph.D. is Professor and Chair of Rehabilitation Sciences at Temple University in the United States

Community inclusion is a longstanding concept in the disability field that has been increasingly applied in the context of behavioral health services for individuals with psychiatric disabilities.

The concept consists of two essential commitments:

1. individuals who experience disabilities, including psychiatric disabilities, have an opportunity to fully participate in the community
2. communities actively seek out and welcome the participation of everyone, valuing each individual's uniqueness and abilities.

The critical importance of community inclusion emanates from its place as a human right, an economic and moral imperative, and as a medical necessity (Salzer & Baron, 2016). While the need to focus on community inclusion in the behavioral health sector is clear, the paths and methods are less so. The goal of this article is to articulate some of the initial set of steps – certainly not exhaustive – that will likely be needed to move forward in a positive direction. These steps fall into four areas: knowledge and orientation, policies, programs, and the role of community.

Knowledge and orientation

Steps toward promoting community inclusion require corresponding beliefs and attitudes among all stakeholders, especially policymakers and providers. My colleague Rick Baron and I have argued that, first and foremost, it likely requires a primary understanding of people diagnosed with a mental illness as whole people with similar hopes, dreams, desires, and capabilities as anyone else who does not have a diagnosis. We call this a 'John the Person' orientation (Salzer & Baron, 2014).

The alternative is reducing our understanding and stories about individuals with psychiatric disabilities to diagnoses, symptoms, missteps and calamities, the extent to which they are engaged in services, and happy endings that involve sitting on a couch, watching TV,

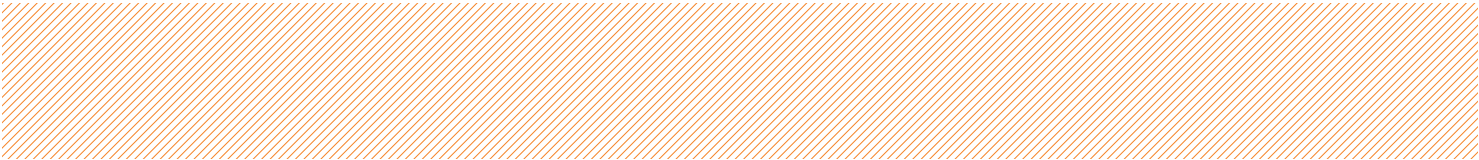
and drinking soda, with little hint about who they are as people or successes they can have. We call this the 'John the Patient' orientation.

The 'John the Person' orientation will lead to an easier time comprehending that people with mental illnesses, including those diagnosed with schizophrenia-spectrum disorders, bipolar disorder, and major depression, would, could, and should participate fully in their communities in ways that are meaningful to them. Such participation is argued to be medically necessary (Salzer & Baron, 2016).

Other changes in orientation are around concerns about risk and liability involving the consumer and the provider – the latter involving fears about the loss of one's licence or credential if something happens to the consumer they supported, which is sometimes mentioned by providers as a major concern and was raised during my recent visit to Australia. It should be kept in mind that risk is an inherent part of living, and that the dignity of risk, including learning from one's own mistakes, should be equally afforded to persons with disabilities (Perske, 1972) as to anyone else in society. Such a perspective should not lead to thoughtless application, however, and my colleagues and I have developed an approach that can assist in the identification of potential risks, plausible assessment of potential harms, and strategies for preventing these harms or ameliorating them if something bad does happen (Burns-Lynch et al., 2011).

Policies: concerns and opportunities

During my recent visit to Australia I was struck by the dramatic changes in policies affecting the behavioral health and rehabilitation service structure across the country. While I am certainly no expert on the changes, some concerns and opportunities come to mind, related to the promotion of community inclusion as a result of these changes.



The 'John the Person' orientation will lead to an easier time comprehending that people with mental illnesses, including those diagnosed with schizophrenia-spectrum disorders, bipolar disorder, and major depression, would, could, and should participate fully in their communities in ways that are meaningful to them.

The first concern is a possible limiting of the numbers of people getting access to rehabilitation services as part of the National Disability Insurance Scheme (NDIS) to only those with the most significant impairments. Such a possibility would be a regressive move that not only fails to promote community inclusion for all individuals with psychiatric disabilities but also has the potential to drive up health and behavioral healthcare costs as a result of cutting "medically necessary" rehabilitation services to those who have previously benefitted from them.

The second concern is that the NDIS scheme over-emphasises basic independent living (i.e., activities of daily living and instrumental activities of daily living) and personal assistant supports while under-utilising evidence-based community inclusion supports that rapidly get people back to work, school, parenting, dating, religious and spiritual engagement, and leisure/recreation, and provide the long-term supports to help them maintain these valued social roles. The opportunity lies in expanding a focus on and funding for community inclusion as part of the Primary Health Networks (PHNs) through the recognition of the physical and behavioral health benefits of community inclusion and participation as a medical necessity.

Programs: supporting new priorities

One challenge that our field has in promoting community inclusion is the need to develop new programs in areas (e.g., education, dating, and spirituality) that were not prioritised in the past and get them to be widely adopted. I certainly learned about some of the wonderful programs and initiatives that are happening in Australia, especially in promoting peer support, education, and spirituality, but suspect, like elsewhere around the world, that further development is needed which requires both funding and acceptance and utilisation from within the behavioral health community.

A second challenge is the development of initiatives that help people with psychiatric disabilities to know about and access mainstream resources that are available to all citizens, rather than depending solely on resources within the healthcare and rehabilitation systems. It is understood that, in most cases, these mainstream resources (i.e., non-healthcare or rehabilitation funded) in the areas of housing, employment, education, leisure/recreation, spirituality, dating,

parenting, etc., are more plentiful than most healthcare and rehabilitation systems will ever be able to afford. Supports need to be offered to both consumers and these mainstream organisations to ensure that they are utilised successfully.

A third challenge is to expand and utilise natural supports, which include family members, friends, neighbors and other community members, work supervisors and co-workers, clergy, and anyone else from whom the person is interested in obtaining support. This creates supportive relationships that are more like everyone else and decreases dependence on paid supports (i.e., health and rehabilitation providers). Programs such as St Vincent De Paul Society's Compeer and the Anglicare Mental Health Project, for example, work to expand social networks between those with and without a mental health diagnosis, and typically involve participation in leisure and recreational activities.

Circles of Support is a model whereby a paid supporter works with an individual to identify their community inclusion goals and the people they wish to approach for support in seeking these goals. The paid supporter then works in partnership with the individual to reach out to those they identified to request their support, organise a meeting to discuss their goal(s) and how the supporters can assist, and then schedule regular meetings to review progress and maintain coordination among the unpaid supporters. One potentially attractive aspect of these approaches for funders is that they involve expanding the availability of supports for persons with psychiatric disabilities without a significant expansion of staffing costs.

The role of community

As mentioned earlier, the second commitment of community inclusion is a community that actively welcomes and seeks out individuals with psychiatric disabilities. By community we mean the larger society, neighborhoods or local community, as well as specific organisations (e.g., work, gym, university, football club). Key to this is to develop even more effective strategies beyond mental health awareness weeks, months, or walks, and public service announcements, to effectively address the very active prejudice and discrimination that exists towards persons with psychiatric disabilities in all areas of life.

In the end we need to keep in mind that community inclusion is about, and benefits, all of us.

Community inclusion is a relatively new concept in mental health. Therefore, it is not surprising that we have much to learn about the individual needs and environmental barriers that are associated with meaningful community participation, and much to learn about the types of interventions and strategies that are needed to make full inclusion possible.

Prejudice and discrimination plausibly account for much of the reason why people with psychiatric disabilities are not fully participating in the lives of their community and have shown to be quite irrepressible despite our current efforts. New approaches need to be developed, including an expectation of engaging in anti-prejudice and discrimination efforts all-day, every day of the year.

These efforts also need to target the beliefs and attitudes of mental health service providers who have been found to have similar beliefs and attitudes towards persons with psychiatric disabilities as the general population (Wahl and Aroesty-Cohen, 2010). We are needed on the frontlines to truly reduce the prejudice and discrimination that exists.

It is also important to discover what specific actions can be taken to create spaces that are welcoming of individuals with psychiatric disabilities. The Temple University Collaborative on Community Inclusion (www.tucollaborative.org), for example, is undertaking a study to identify non-behavioral health settings, such as: coffee shops, gyms or yoga studios, a church or other place of worship, and other places where people feel welcomed, and then identify the physical, social, and behavioral characteristics of these settings that make them welcoming.

We expect, for example, that such settings might offer areas that are less sensory stimulating for those who might be affected by too much light, sound, or movement at times, or comprise of people who are open and accepting of different appearances and behaviors, or are flexible in terms of what people are expected to do in order to be in that space. We hope to take this information and share it with various settings to help them become more welcoming.

Finally, we need to further identify strategies to assist society and organisations to move beyond being just welcoming and accommodating spaces and toward actively seeking out persons with psychiatric disabilities in recognition that diverse communities benefit everyone. Strategies such as hiring or enrolment goals, sometimes with incentives, have been used around the world, and similar goals could be established in other settings (e.g., men's clubs, religious settings, etc.). Less targeted strategies could be used as well, including simple outreach from community organisations, places of employment and elsewhere to individuals with psychiatric disabilities, their families, or organisations that support them.

Conclusion

Community inclusion is a relatively new concept in mental health. Therefore, it is not surprising that we have much to learn about the individual needs and environmental barriers that are associated with meaningful community participation, and much to learn about the types of interventions and strategies that are needed to make full inclusion possible. This brief article lays out some of the initial steps as I see them now. I look forward, however, to further thought, dialogue, and experimenting from all of us. In the end we need to keep in mind that community inclusion is about, and benefits, all of us.

Acknowledgements: The contents of this article were developed under a grant from the US Department of Health and Human Services, Administration for Community Living, National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR; 90RT5021-02-01; Salzer, PI). The contents of this article do not necessarily reflect the views of the funding agency and you should not assume endorsement by the US Federal Government. I also want to thank Rick Baron for his partnership and conversations about these issues.

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Supported decision making and mental health advocacy



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The Mental Health Act 2014 introduced the principle of supported decision making into mental health service delivery. Independent Mental Health Advocacy (IMHA) was established as one key strategy to support people to be involved in the treatment decisions made about them. This paper introduces IMHA and the principle of supported decision making, and discusses some of the ways that Mental Health Community Support Services can support consumers to express their treatment needs and preferences.

About IMHA

Independent Mental Health Advocacy (IMHA) provides non-legal advocacy to people on, or at risk of being placed on, compulsory mental health orders in Victoria. Funded by the Department of Health and Human Services (DHHS), IMHA began operation across Victoria in August 2015.

IMHA is part of the range of services provided to Victorians by Victoria Legal Aid (VLA). Its advocates work closely with VLA's Mental Health and Disability Law (MHDL) team to provide legal and non-legal advocacy support to people living with mental health issues.

IMHA's team consists of 17 staff: 14 mental health advocates, a senior consumer consultant, an administrator and a service manager. Five advocates work out of VLA's Melbourne office, and VLA's premises at Dandenong, Geelong and Bendigo each house three advocates. This enables IMHA to provide a statewide service, with advocates regularly visiting every designated mental health service across the State.

IMHA advocates have a range of backgrounds including consumer and carer lived experience, social work, community development, law and mental health nursing. They can provide information, referral, coaching for self-advocacy and advocacy on any matters pertaining to individuals' mental health assessment, treatment or recovery. IMHA provides

directions-based advocacy, meaning that the role of the advocate is to support the person's own wishes and preferences to be heard and respected by services. Advocates work alongside people and support self-advocacy wherever possible.

IMHA's service model involves the advocates regularly visiting acute mental health units (including adolescent and aged services) and other residential mental health facilities (Secure Extended Care Units, Community Care Units and Prevention and Recovery Care services) across the State. Each advocate is also rostered on to respond to the service's intake phone line, ensuring that people calling the service can immediately talk to an advocate to gain information and support for their issues. An important part of IMHA's role is to work with clinical mental health services to assist them to adopt the principle of supported decision making into their everyday practice.

Expansion of Mental Health Advocacy

IMHA is only the newest advocacy service in Victoria for people subject to compulsory treatment in Victoria. The Victorian Mental Illness Awareness Council (VMIAC) has been providing non-legal mental health advocacy in Victoria since the 1980s, and continues to play a vital role in advocating for individuals who are not eligible for IMHA's services as well as undertaking systemic advocacy work.

A legislated move towards supported decision making is a big step on the path towards less coercive and more trauma-informed responses to people's mental and emotional states of distress.

VLA has greatly expanded its offer of legal advocacy for people experiencing compulsory mental health treatment in recent years, and the Mental Health Legal Centre (MHLC) continues to contribute its legal expertise to advocate for consumers in a range of ways.

Generic disability advocacy services and the Office of the Public Advocate (including its Community Visitors Program) are also important contributors to the advocacy landscape.

As well as their direct work with individuals, community mental health service staff have always played a key role in advocating alongside, or on behalf of, the people who access their services. This aspect of their work has always been very highly valued by consumers, and forms a large part of the advocacy that happens in Victoria.

Supported decision making in clinical mental health services

Our understanding of mental illness, trauma and distress has grown enormously in recent years, largely through people with lived experience of these states talking about their experiences, and about the service responses they identify as being most useful.

A much greater recognition that mental health issues for many people derive from their life circumstances and experiences (as opposed to a purely biomedical, deterministic model of mental illness) has necessarily required policy makers and service providers to reconsider the impact on individuals of restrictive interventions and coercive treatment. International and local human rights laws (most particularly the United Nations Convention on the Rights with People with Disabilities and Victoria's Charter of Human Rights) have also challenged the prevailing wisdom that in some circumstances coercive treatment can be good for people, or secluding or restraining individuals against their will can be therapeutic.

Evidence that people taking psychiatric medications for extended periods have a greatly reduced lifespan (for example Lambert et al., 2003) and that the medications used to treat people frequently create or contribute to serious physical and mental health consequences (Joukamaa et al., 2006) adds weight to the assertion that people should have the right to decide for themselves, to the greatest extent possible, the best possible treatment response that takes into account all of their particular circumstances.

The Victorian Mental Health Act 2014 signalled a shift in mental health service provision towards more recovery-oriented clinical services, with voluntary treatment explicitly favoured over compulsory treatment, greater oversight of restrictive interventions, and a new emphasis on supported decision making. While legislation can't create cultural change, the Act envisions a rights-focused service system and provides a stronger framework within which cultural change can occur.

A legislated move towards supported decision making is a big step on the path towards less coercive and more trauma-informed responses to people's mental and emotional states of distress. It signals a greater understanding of the negative impacts of people having things 'done to them' and a profound shift towards supporting greater autonomy, more individualised service responses and a genuine belief in people's capacity to learn from their experiences and to find their own answers to their life issues with appropriate support.

Specifically, the Act outlines 12 Principles that provide a framework for service delivery for all funded mental health services. All mental health services, including Mental Health Community Support Services (MHCSS) and IMHA, "must have regard to the mental health principles in the provision of mental health services." In this context it is important to note that the Principles apply to "persons receiving mental health services" and not only to people subject to compulsory treatment under the Act.

The principle of supported decision making means that, rather than a psychiatrist unilaterally deciding the best course of treatment on behalf of a person receiving mental health treatment, the person is provided with support to make, or participate in, decisions made about them to the greatest extent possible.

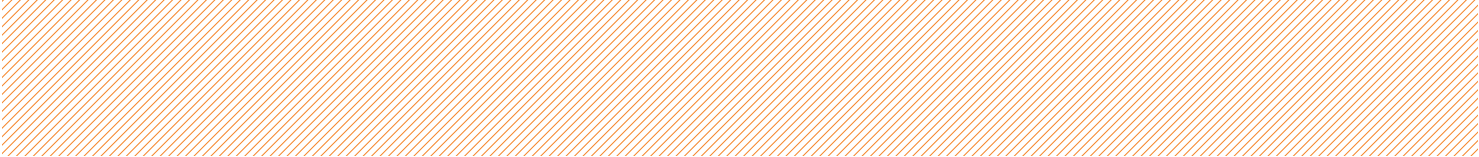
The third, fourth and fifth Principles of the Act relate directly to supported decision making, and state:

- (c) persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected;
- (d) persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk;
- (e) persons receiving mental health services should have their rights, dignity and autonomy respected and promoted.

The Act provides for several measures to support the greater involvement of people in the decisions that affect them, including:

Advance statements

Advance Statements provide an opportunity for people to express in writing their mental health treatment preferences should they be subjected to compulsory mental health treatment. The Act stipulates that psychiatrists must have regard to a person's advance statement when making compulsory orders and treatment decisions. Advance Statements can be overridden by psychiatrists if they are satisfied



that the preferred treatment is not clinically appropriate or is not a treatment usually provided by the mental health service. People can request a written statement of reasons for why a psychiatrist chose not to abide by their treatment preferences expressed in an Advance Statement.

Nominated Persons

The Nominated Persons scheme allows for people to nominate a trusted person in their lives who is empowered by the Act to communicate with mental health services on behalf of the person should they become subjected to a compulsory order. Nominated Persons' roles and responsibilities are defined in the Act as:

- (a) to provide the patient with support and to help represent the interests of the patient; and
- (b) to receive information about the patient in accordance with [the] Act; and
- (c) to be one of the persons who must be consulted in accordance with [the] Act about the patient's treatment; and
- (d) to assist the patient to exercise any right that the patient has under [the] Act.

IMHA

While it wasn't initially written into the Act, the State Government committed to funding an advocacy program for people subjected to compulsory mental health treatment at the time the Act was introduced into Parliament. The advocacy program has benefitted from bipartisan support, and in 2015 IMHA was included as a prescribed body in the Mental Health Regulations, meaning that people subject to the Act cannot be denied access to an IMHA advocate.

Compulsory and voluntary treatment

The Act states that "persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery". However, the key mechanisms to support this principle only apply to people on compulsory orders. Members of the consumer community are increasingly speaking out about the rights of voluntary (including private) mental health consumers and how even voluntary treatment can feel very coercive in some circumstances.

The role of the community mental health sector

The recommissioning of community mental health services in 2014 allowed for a clearer articulation of the expectation that people could choose the services they wanted in the lead-up to the rollout of the National Disability Insurance Scheme (NDIS). The reform of MHCSS has been plagued with problems for consumers, staff and organisations including uncertainty around who is now receiving services (and who is not), long waiting lists, barriers to accessing services (i.e. intake processes), a lack of choice of provider in some regions, uncertainty for staff and the potential loss of valuable expertise across the sector. Despite these challenges, the sector has continued to develop ways of working with people that support individuals towards greater autonomy, to define their own goals and ambitions and to be supported to make decisions on their own behalf.

Thus, within MHCSS, supported decision-making is the assumed way of working with people and the sector holds considerable expertise in working in this way. Consumers generally tend to engage with these services and staff tend to be highly skilled in developing positive relationships with people. Thus MHCSS have a great deal to contribute to the shift towards supported decision making. With many regions now developing closer links between clinical and non-clinical mental health services, and some clinical services recognising the valuable expertise held in the community sector, we can expect the capacity for MHCSS to influence their clinical colleagues towards more person-centred ways of working to increase over time.

Due to the impact on people's human rights of being detained in facilities, IMHA prioritised setting up outposts in inpatient units. As the service continues to expand its reach, advocates are seeking opportunities to talk with staff, consumers and carers in community settings about advocacy and supported decision making. MHCSS can play a very useful role in supporting people on community treatment orders to access IMHA, and supporting IMHA to communicate with the broader mental health community.

One of the disappointing factors at this stage in the life of the Act is the low uptake of the supported decision-making tools of Advance Statements and Nominated Persons. While some activity is underway to improve this (most notably by the Mental Health Legal Centre establishing a "clinic" to support people to write an Advance Statement), MHCSS are also well placed to provide support to their clients to document their treatment needs and preferences. Some IMHA advocates have already provided information sessions to MHCSS staff about advance statements, and IMHA will respond to any requests from services to support them to develop these skills. Likewise, the nature of the relationship between consumers and their MHCSS worker means that MHCSS are well placed to support people to identify, and nominate, a person to act in the role of nominated person.

Supporting people to learn the skills to be able to self-advocate forms a natural part of the work of MHCSS, and many services have already undertaken this work. As the NDIS rolls out, the need for consumers to be supported to advocate for their needs, and access the advocacy services they need, will only increase.

Contact IMHA

IMHA's intake phone number is 1300 947 820 or you can contact us via our administration line on (03) 9093 3701. People can also make contact via our website at www.imha.vic.gov.au.

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Coproduction as a methodology



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I think of coproduction as a methodology – a way of doing work among ‘unlikely bedfellows’. I am interested in coproduction because it offers one way to push consumer contributions to knowledge, service and policy development out from under the yoke of ‘participation’ and into the arena of operational consumer leadership and capacity building. But it should also be understood that consumers bring more to coproduction than their direct experiences of recovery and of using services.

Over time, consumers have developed unique ways of knowing, theorising and thinking about those experiences that constitute a *unique discipline* in the field of mental health known in Australia as ‘consumer perspective’. When using consumer perspective, consumers “offer their own *analyses* of their experience and of the services and systems they encountered” (Russo and Beresford, 2014). Consumer perspective contributes analysis, thinking, and critique beyond the context of service improvement and into broader policy, academic, educational and research contexts.

The first part of this paper talks more generally about coproduction – what it is and what it isn’t – before looking at using coproduction methodologies in the public mental health sector. While my focus is on consumers, observations can be generalised across other groups.

What is coproduction?

In the context of public service commissioning and development, coproduction describes partnerships between government, service providers, service users, communities or citizens that are values based and use cooperative processes (Boyle & Harris, 2009). It is based on

the principle that communities have essential knowledge about their own context that is a vital resource in shaping services that meet community needs.

Coproduction is hard to define, partly because of its varied origins that include social policy around personalised care (Charles Leadbeater), ideas about ‘time banking’ (Edgar Cahn) and new ideas about product/service design by working with ‘end users’ (co-design) (SCIE, 2015).

In the academic context, coproduced research involves deep partnerships between academics and people who have traditionally been ‘researched upon’. In the context of research, coproduced knowledge has been described as “a blurring of the boundaries between scientific practitioners and those on the receiving end of scientific enquiry.” (Nowotny, Scott, & Gibbons, 2001, in Gillard et al., 2012: pp. 1127). This blurring is a deliberate up-ending of traditional notions of who holds ‘expertise’, who is a researcher, what knowledge is and how it is generated. The word ‘deliberate’ is key here. One of the features of all coproduced work is that it pays constant and close attention to processes of power.

How is coproduction different from co-design?

While co-design involves all parties *designing* the project together, coproduction also involves the project being *delivered* by all parties (Grey, 2014). It is not possible to engage in robust coproduction without also engaging in co-design. However, coproduction is different from co-design because the knowledge and skills are embedded in *every step of the process*, from deciding on what the problem is to designing, implementing and reviewing solutions. At its best, this way of working unleashes transformative potential because it can create:

“...a culture of enabling and facilitating, in order to build capacity for people to help themselves and each other. Professional expertise is valued but does not replace the knowledge that comes from personal experience; real transformative change comes from combining all kinds of expertise” (Hashagen et al., 2011).

What is radical about coproduction methodology?

An explicit goal of coproduction is to reposition people who have traditionally been thought of as passive ‘consumers’ of services to being regarded as people with necessary expertise who can lead thinking and innovation. Coproduction raises the bar – from seeking involvement or participation after an agenda has already been set to seeking consumer leadership from the outset so that we are engaged in the initial thinking and priority-setting processes. Coproduction methods force us to confront power and influence: who has it, who doesn’t. Cahn stresses that coproduction is not necessarily smooth and co-operative, that it may involve confrontation, or “take the form of a dialectic that yields parity, only after a struggle because the process entails a shift in status that may be embraced or resisted” (Cahn, 2000).

Confusion about coproduction

While there is burgeoning interest in coproduction, the literature shows diverse meanings and concepts which cause confusion. Table 1 sets out some of the different lenses through which participation and thus coproduction is viewed. The shaded rows depict concepts associated with coproduction that are adopted in this paper, while the unshaded rows depict concepts that I would contend are misleading and wrongly associated with coproduction because they fail to characterise consumer leadership.

Table 1: Variable concepts associated with coproduction from the literature (Grey & Roper, 2015)

Participation lens	Example
Democratic	People’s right to participate. Current consumers offer expertise from lived experience of services and self-management; focus is often on improving service quality, e.g. involvement in consumer advisory group.
Therapy	Involvement is seen as beneficial for the person, e.g. learning new skills.
Social marketing/ behavioural psychology	Citizens are more likely to understand and appreciate social policies if they are directly involved; e.g. people who help to tidy up their local park are less likely to allow their dogs to foul it.
Self-determination	Involvement is political – development of consumer leadership and the building of capacities at the individual and group levels, e.g. supported decision-making, consumer unions.
Social justice	Focus is on redressing imbalances in social power, e.g. opportunities are built into work.
Giving back	Having social rights and responsibilities; having a contributing life, e.g. volunteering.
Expert patient	Knowledgeable about one’s condition, usually within a medical paradigm; assisting other consumers; e.g. to navigate service systems or use first-hand experience to educate patients about treatments.
Expertise	Specialist knowledge sets applied to work; includes direct experiences of recovery and/or service use; training; work experience; life skills etc.
Community development	Coproduction is an end point with ‘engagement and empowerment’ being the processes through which the endpoint is achieved (Hashagen et al., 2011).
Therapeutic relationship	Coproduction used synonymously with the term ‘shared decision-making’ to describe a therapeutic partnership between service providers and consumers (Alakeson et al., 2013).

Consumer perspective contributes analysis, thinking, and critique beyond the context of service improvement and into broader policy, academic, educational and research contexts.

What are the principles underpinning coproduction?

Adopting coproduction as a methodology in mental health might involve people with institutional power working alongside people who have used services through compulsion/coercion and have even been traumatised by their service use, and yet it is these experiences they draw upon to inform their work. The literature on coproduction (for example, publications by the UK think tank NEF) does not offer guidance about such circumstances.

Three core principles are suggested here to increase consumers' power and influence:

1. Consumers are involved in setting the priorities/agenda from the outset

To give an example of what can go wrong if consumers are not engaged for their thought leadership from the beginning, a government initiative intending to adopt a coproduction methodology had to backtrack when it was realised that too many of the parameters had already been set, including the amount of funding, how it would be allocated, timelines, and what model would be used. The problem and solution had already been identified before a coproduction approach was considered. Another hitch can be when there is insufficient transparency/clarity about 'non negotiable' components of a project which can cause feelings of frustration and disengagement.

2. Power differentials are explored, tabled and ameliorated

Coproducton is often described as involving 'equal and reciprocal relationships' (e.g. Slay & Stephens, 2013), but this aspirational statement does not give any guidance as to how to correctly identify inequalities or how to shift relationships away from more traditional, hierarchical relationships to ones where issues of power are consciously attended to. Affirmative action techniques and reflective questions can be effectively built in. Good questions are: how am I privileged in this space? What do I need to do to create a space where people with least power can take up influence? What am I bringing to this project and what am I learning?

3. Growing consumer leadership/building consumer capacity

Time, resources and opportunities for building the leadership, confidence and capacities of consumers are prioritised in coproduction as strategies to compensate for inequality. In reciprocal fashion, governments, services and service providers are also likely to need to build their own capacity so they can reposition consumers as leaders:

"Community development support may equally be needed with service providers to better equip them to engage with communities and in particular disadvantaged or excluded community interests (Scottish Community Development Centre, 2011)."

Who sets the agenda/priority in coproduction?

Regardless of whether the coproduction initiative is conducted in partnership with government, services, providers, service users, communities, citizens, or academics, reflecting on who sets the agenda (or decides what the priority area to work on will be) is the first crucial step. This is because distribution of power and decision-making will depend upon who has set the agenda. Consumer-led initiatives are the most obvious and effective way to address power imbalances. A simple typology for delineating between different modes of agenda setting is as follows:



Supported decision-making training at the Centre for Psychiatric Nursing

One example of a consumer-led agenda for coproduced activity is the highly successful supported decision-making training that I have developed at the Centre for Psychiatric Nursing (CPN) as the consumer academic. From teaching a supported decision-making module as part of the post graduate diploma in mental health nursing at the University of Melbourne, I identified a knowledge and skills gap in the mental health workforce on the principles underpinning supported decision-making. Using content from the teaching as a basis, I then sought a partnership with CPN clinicians to develop curricula and deliver a full day supported decision-making workshop to the mental health specialist workforce (Roper et al., 2014).

How to test if the coproduction context and methodology is right?

This is an exciting time in coproduction, with the Victorian Government's commitment to adopting coproduction methodologies, growth internationally in coproduced research, and the development of initiatives such as Recovery Colleges and coproduced training.

However, as a final comment, not all projects are suitable for coproduction methods. The following reflective questions (Grey & Roper, 2015) can be used as discussion points to support mutual decision-making and understanding prior to project commencement and during initial coproduction group meetings to help understand if coproduction is possible in the context and if it is the right methodology.

Have we discussed/worked out:

- Why we have opted for coproduction (rather than consumer-led or consumer participation)?
- Who should be at the table, helping to define the problem/set the agenda?
- Why these particular consumers? What expertise/experience/service usage is relevant for this work?
- How we find the people who are most affected by the problem/should set the agenda?
- Who else needs to be involved if this is to be effective/relevant?
- How we can bring consumers in as early as possible to be involved in decision making/direction setting?
- How we can prevent the process from being tokenistic?

- Whether there are enough consumers in the room?
- How the power can be redistributed within the partnership?
- Whether consumers can fundamentally change the parameters of the project?
- What investment we need to make in strengthening consumer leadership/capacity (e.g. training/paying for service user expertise)?
- What training partners might need in consumer perspective/leadership?
- Whether consumers have autonomy? Is there trust? Is the process trauma-informed?
- Who stands to learn from this process?
- Who stands to gain what in this process?
- How we can move closer towards coproduction for future work?
- Whether everyone is ready for coproduction/how we would know/what needs to happen?
- How we can make our first meeting feel different from usual meetings (accessing our creativity, 'breaking bread' together or choosing an unusual meeting place)?
- At the first meeting: whether we have correctly identified the problem? What we all see the problem/agenda as?

Acknowledgements: I would like to acknowledge the work of Flick Grey and Emma Cadogan for their considerable contributions, members of the Psych Action and Training group and other consumers and the many clinicians, researchers and bureaucrats who continue to advocate for coproduction.

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Ready for disruption? Putting social change at the centre of the agenda



Marion Blake is CEO of Platform Trust New Zealand

Matariki is the Māori name for a cluster of stars that rise in the New Zealand winter and signal new beginnings; a time for connecting and giving thanks, a time to turn to the future and celebrate new beginnings. The *Matariki* constellation serves as a symbol of the future that we are creating; no individual, single organisation, group of people or point of view has a starring role, the future we are creating will take all of us.

Platform Trust is a New Zealand collaboration of community organisations whose work is providing services to individuals, families and communities where mental health and addictions are issues. As a membership organisation we have focused our attention on the shared problems that inhibit our members' ability to deliver good services, such as: inequality between the government and non-government sector, poor government contracting practices, lack of investment in the community workforce and an overall lack of recognition of the role of the community sector.

The mental health system may have served us well in the past, however there is now overwhelming evidence about the huge personal, social and economic costs of mental ill-health and addictions, and we now know the impact of poor mental health extends beyond individuals and families to communities, schools, prisons and workplaces.

The way we are doing things must change and there is no one agency that can solve these complex social issues. Catch-phrases like 'mental health is everyone's business' or 'no health without mental health' might work for a campaign but are at risk of becoming meaningless clichés without focused attention about what mental health service providers need to actually do differently. The endless supply of policy and strategy documents constantly fail to address the systemic issues. 'Top down' approaches rarely bring fundamental change, which needs to be embedded in community and through the layers of complexity that make up modern health and social systems.

The problems have been identified over and over again and now it's time to reach beyond the culture of blame and competition. There is a long way to travel if we are to put social change at the centre of the agenda, create shared responsibility, and collaborate across the whole community system. While occasionally there have been wins, the core issues have remained.

We decided to change course, lead from the front, find some partners and together do what we could to transform the way the system works.

'Disruption innovation'

Social technology is one area of new invention and innovation. We are seeing increasing supportive evidence that social design, social network theory, collective impact, complex adaptive systems theory and collaborative theory are gaining traction through application and adaptation.

American writer Clay Christianson has coined the phrase 'disruption innovation' and has written extensively about this through the lens of business. It is not difficult to see the impact in travel, banking, communications, media and increasingly in general health. We have seen disruptive innovation become the new normal – for example last year the cofounder of Uber raised US\$14 million to set up 'Uber for Healthcare'.

The health sector has evolved through specialisms and specific areas of clinical knowledge often occurring in isolation and often far from the social determinants of health. Creating new networks across silos and including new technologies is critical for the systems change required in mental health.

The following are two practical examples of work and ideas that Platform has been involved in to demonstrate the impact of doing things differently. They are initiatives that use the 'crowd' to build a network and they support understanding the assets that already exist and using the data to co-create the system.

NZ Navigator www.nznavigator.org.nz	Purpose	Description	Impact
<p>The political environment was talking about 'too many' non government organisations (NGOs). As 30% of the national mental health and addiction budget goes to NGO services, Platform Trust was asking: "What does it take for an NGO to be 'fit for purpose' to contract with the Government?"</p>	<p>To develop a resource through which community organisations could assess their own capacity and identify areas where they needed to develop.</p> <p>To enable the sector to understand its strengths and weaknesses.</p>	<p>An online tool for community organisations to assess their capability across following domains:</p> <ul style="list-style-type: none"> • direction • governance • leadership • people • administration • finances • communication • evaluation • relationships. <p>Results are collated, presented back and rated in a star graph. Links are provided to information to assist in improving performance.</p>	<p>Community organisations were taking control and could identify actions for change.</p> <p>Originally intended for mental health and addiction services, the tool can support community development and build community capability across sectors. More than 1,160 organisations registered from many sectors, e.g. social services, health, culture, sports and recreation, education, research, grant making, fundraising and volunteering, housing, religion business and professional associations, environment, law, advocacy, politics and international development.</p>
Equally Well	Purpose	Description	Impact
<p>Using a creative 'crowdsourcing' approach, Te Pou o Te Wakaaro Nui (the national workforce centre) produced a New Zealand evidence review about the poor physical health of people who live with mental illness and addictions.</p> <p>Equally Well has evolved as a broad, collectively owned collaboration that draws attention to these issues for all people in the health system, and encourages clinicians to act within their sphere of knowledge, e.g. oral health, prescribing, general practice, etc.</p>	<p>To find 'a crowd' that cared and had a contribution to make to improving physical health care.</p> <p>Using the crowd to build a network, using the data to show others how their expertise was needed.</p> <p>To draw on a diverse range of people and connect with people who live with mental illness and addictions to provide real feedback.</p>	<p>A network of individuals and entities (with a backbone function undertaken by one organisation) that:</p> <ol style="list-style-type: none"> 1. signs up to an Equally Well charter 2. is connected using www.loomio.org – an online participatory decision making tool that connects and enables dialogue beyond traditional organisational barriers 3. sets its own goals (individual or professional) and shares information. 	<p>The connection between physical health and mental health is being made.</p> <p>Equally Well has been taken into the language of the mental health sector.</p> <p>Equally Well has provided an entry point for General Practice into mental health.</p> <p>Different workforce groups (clinic nurses, dieticians, physical therapists, oral health practitioners, etc.) are realising they have a contribution to make to mental health.</p> <p>Local initiatives are springing up.</p> <p>People with experience of mental illness and addictions are actively involved in the discussions.</p>

The way we are doing things must change and there is no one agency that can solve these complex social issues.

What we are learning:

From developing and running NZ Navigator we learnt:

- community organisations have similar needs, so let's share more
- take risks but manage the process – in our case, we balanced a young team of developers with an experienced project manager with community knowledge
- test, adapt, test, adapt and keep the end user in mind.

From Equally Well we learnt:

- there are so many other world views and asking for help is OK
- when people can see their part of the picture they are usually happy to be responsible for that bit
- collaboration with unlikely people who do things that we don't all know can help
- diversity matters: having a wide conversation through multiple lenses offers more solutions
- good ideas travel fast
- start anywhere – just start ...many small actions will bring change.

From other industries in the start-up and technology world we learnt:

- lean and agile development builds innovation and brings a customer focus into everyday practice and builds team transparency
- design starts with enough of an idea to then test on the customer for feedback, in contrast to a service designed by staff or committee then rolled out
- 'Stand Ups' are useful – short daily meetings to keep the team on task, on track, accountable to each other and learning together
- 'sprints' are a specific duration, for example one week, two weeks, one month to have agreed work completed and made ready for team review.

Conclusion

Taking a wider view about how we can transform the system and who we can engage to help has been liberating. Innovative disruption has something to offer the community health and social sector and we should be prepared to be bold. We don't need to start at the beginning and there are many industries, 'start-ups', and innovation laboratories whose experience, successes and failures we can draw on. As community agencies we have our own specialist knowledge and that must be counted and valued.

Community development across complex issues will require us to behave like *Matariki*, a constellation, where no individual, single organisation, group of people or point of view has a starring role; the future we are creating will take all of us.

Catch-phrases like 'mental health is everyone's business' or 'no health without mental health' might work for a campaign but are at risk of becoming meaningless clichés without focused attention about what mental health service providers need to actually do differently.

Transition to change: Reflections on the ACT NDIS Trial



Simon Viereck is Executive Officer, Mental Health Community Coalition ACT

The National Disability Insurance Scheme (NDIS) Trial commenced in the Australian Capital Territory (ACT) on 1 July 2014, one year after the commencement of the first trial sites. The ACT Trial Site is the only whole-of-jurisdiction, whole-of-population trial. This means the ACT has a unique perspective on the likely impact of the implementation of the NDIS. As the peak body for the community managed mental health sector in the ACT, Mental Health Community Coalition ACT (MHCC ACT) is well placed to monitor this impact. So what has our experience been?

Our starting point

The ACT has seen steady and significant growth in government funding for mental health services for a decade. The range of services provided by the community-managed mental health sector has expanded to include sub-acute services, an outreach service for people exiting detention, specialist education and mental health promotion services, and other new initiatives. Commonwealth investment saw the introduction of the Personal Helpers and Mentors (PHAM) programs and Partners in Recovery. Funding for community managed mental health services as a proportion of the total mental health services budget has been one of the highest in the country.

The ACT Government also supported quality improvement and workforce development initiatives. Through this support MHCC ACT was able to implement a program of subsidised training in Certificate IV in Mental Health and Certificate IV in Mental Health Peer Work. By 2014 we estimated that at least 75 per cent of the community managed mental health sector workforce was qualified at a Cert IV level or higher.

The sector also reported being able to increasingly attract people with higher qualifications and more experience – despite the competition posed by higher wages in the government sector. MHCC ACT also supported organisations to pursue accreditation against the National Standards for Mental Health Services and to foster a culture of collaboration, cooperation and continuous improvement.

Preparation for NDIS

Eighteen months out from the commencement of the ACT NDIS Trial the ACT Government formed an NDIS Taskforce, which was charged with using NDIS Sector Development funds and ACT Government funding to undertake a range of activities to help the disability and mental health sectors prepare for and implement the NDIS. Importantly the Taskforce included a Mental Health Specialist Officer. The Taskforce quickly began to work collaboratively with the ACT office of the National Disability Insurance Agency (NDIA) and the relevant peak bodies: National Disability Services ACT (NDS ACT), MHCC ACT, Carers ACT, and the ACT Mental Health Consumer Network.

The ACT Trial Site is the only whole-of-jurisdiction, whole-of-population trial.

Prior to commencement of the NDIS Trial the Taskforce oversaw implementation of several preparatory initiatives, including:

- a trial of small self-directed funding grants to individuals to purchase services and supports
- Community Conversation sessions with groups of potential NDIS recipients
- workshops on business essentials, international experience of implementing personalised funding, and other topics.

Once the NDIS Trial commenced additional support was funded, including:

- business investment packages of up to \$50,000 and other programs for organisations to implement strategic business change
- small grants for individuals to prepare and plan for NDIS
- a workforce awareness tool with NDIS factsheets and information
- NDIS engagement and planning support for harder to reach groups
- dedicated programs for Aboriginal and Torres Strait Islander people
- planning and wellness support for carers of NDIS participants
- Ready4 portal and program of business support tools and resources.

Communication and collaboration

When implementing comprehensive social policy change such as the NDIS, good communication is critical. Forums were created for this purpose, including a CEO Forum with NDIA established by NDS ACT and co-hosted by MHCC ACT, a meeting of executives of government and community managed mental health services, and a whole-of-mental health sector forum organised collaboratively by MHCC ACT, the NDIS Taskforce and NDIA.

These forums were instrumental in identifying and jointly problem-solving practical challenges during the transition to NDIS. Challenges addressed include a process to cover funding shortfalls for participants whose NDIS transition is delayed, development of a simpler Evidence of Disability Form for people with psychosocial disability, ensuring timely completion of NDIS forms by clinical managers and psychiatrists, working groups on key issues such as transport, and simply ensuring communication flows between NDIA, ACT Health and the community managed mental health and disability sectors.

MHCC ACT also set up a group of frontline workers and team leaders as a community of practice in managing practical aspects of NDIS implementation in provider organisations.

A culture of cooperative relationships between individuals in government and community-managed sectors was also crucial to ensuring providers and peaks could get timely access to key policy and operational officials in government to raise and address issues as they arose.

Local versus national issues

Despite the best efforts, cooperative attitudes and hard work of all involved at the local level, those forums and mechanisms were not able to address key areas of concern, including in areas, such as:

1. the funding and pricing model
2. barriers to access and support for people with psychosocial disability
3. lack of critical information
4. support for people who are not eligible for NDIS
5. safety and risk management for staff and participants.

Our experience is also that the NDIA national office continues to feel remote and unresponsive. Information, concerns and questions have been regularly fed back to the national office from ACT forums and stakeholders with little response received. Major changes were made to the Scheme, but local NDIA officials were given inadequate information and too little time to effectively communicate even that to stakeholders. Despite requests, NDIA has refused to develop more effective mechanisms for information sharing.

The lack of timely information is an example of the apparent attitude towards service providers at the national level of NDIA. David Bowen, the NDIA CEO, has been explicit in suggesting community managed organisations are top-heavy, inefficient and resistant to change. In our experience this not only incorrect, especially when compared to government organisations, but also an arrogant and unconstructive way to approach your critical partner in major reform.

The consumer and provider experience

Mental health sector advocates have long been concerned about the deficit-based language of the NDIS and the concept of 'permanent disability'. It was therefore no surprise that 'permanent disability' presented a barrier for individuals seeking access to the Scheme and for workers supporting them. After decades of recovery-oriented and strength based service, it is not simply a question of getting used to new language!

Providers find that it has generally taken 2–10 sessions and sometimes much more to engage existing participants in conversation about the Scheme and preparing for a planning conversation with NDIS. This period of engagement is not funded by the NDIS and will not generally be possible once the gradual withdrawal of existing funding is completed.

Other access barriers have included GPs lacking understanding of the Scheme or being unwilling to term mental illness a 'permanent disability', clinical managers not prioritising completion of evidence of disability forms, and inadequate understanding of and information about NDIS across the mental health sector.



Our experience is also that the NDIA national office continues to feel remote and unresponsive.

The impact on organisations of business change also cannot be overstated. Organisations have had to dedicate vast amounts of financial and human resources to developing new business processes and ICT systems in a very uncertain and continually changing environment.

While initial satisfaction with NDIS plans for individual participants reportedly remains high, multiple plan revisions have often been required because either participants did not appreciate the need to include all existing supports, or planners – with inadequate understanding of mental health – prepared inadequate plans. MHCC ACT members also observe that many people with psychosocial disability have found the NDIS planning process highly stressful, and some simply can't and won't engage in the process. While individuals within NDIA are willing to respond creatively to this, it too often fails on a systemic level resulting in distress and serious risks for those participants.

Attempting to implement plans often leads to disappointment when seemingly large dollar figures translate into limited support hours or providers are unable to provide supports in a particular way.

An inability to deliver supports is related to the inadequate NDIS pricing framework. Mental health providers across the trial sites report hourly funding rates effectively being halved compared to block funding. It is telling that general disability providers in the ACT also report being unable to viably deliver services at the rates on offer.

What happens next?

The sector's concerns about workforce issues are becoming a reality. MHCC ACT and our fellow peaks have highlighted the potential loss of existing skilled and qualified staff and a de-skilling of the workforce. Our members are already seeing staff leave for more secure and better paid jobs and are unable to recruit suitably skilled new staff at the pay rates they are able to offer. The consequence is that they are unable to offer services to people with NDIS Plans. In turn NDIA officials are growing increasingly concerned and frustrated at the low rates of plan implementation.

Some service providers are attempting to manage viability issues by only providing low-priced supports if the NDIS participant also purchases higher-priced supports from them, effectively aiming to at least somewhat offset losses on support with profits on another. This limits choice and control and undermines the objectives of the NDIS. More often however, providers cross-subsidise from non-NDIS sources of funding.

In time, providers will likely opt to hire the lower-skilled staff they can afford and offer NDIS services. This picture is one of change from recovery-focused psychosocial rehabilitation supports to generalist disability supports.

The withdrawal of block-funding will result in little capacity in community-managed organisations to support people with psychosocial disability to engage with and access the NDIS. This puts the responsibility back on the NDIA and Local Area Coordinators to take up this engagement work. It is unclear what this means for the many people with psychosocial disability who are expected to access the NDIS, but are not yet engaged.

Lastly the Information, Linkages and Capacity Building (ILC) framework which was reportedly designed to minimise the need for individual funding packages, has not materialised yet, and the allocated funding will not enable it to fill this role.

Lessons learnt

Firstly, the pace and scope of change associated with NDIS implementation is astounding, exceedingly ambitious, and completely inadequately planned for. Engaging in highly complex, system-wide and organisation-wide change in a highly uncertain and continuingly changing environment is incredibly difficult. Bigger organisations are more likely to have the necessary resources to manage this, which points to greater risks for smaller organisations.

We have learnt that strong local relationships and communication is critical to managing the combination of rapid change, lack of information, and the host of practical issues and problems arising. Being able to call on contacts in the ACT Government and NDIA for information or to discuss issues has been invaluable for community-managed organisations.

Thirdly the NDIS was not designed for psychosocial disability. The Scheme design lacks understanding of the particular flavour of complexity associated with supporting a person with psychosocial disability. The practical consequences are evident on a daily basis and unfortunately too often result in distress for participants. The psychosocial disability sector needs to continue to advocate loudly and concertedly for changes to better meet the needs of people with psychosocial disability.

Lastly the NDIS 'market' is not a market! Prices are fixed, supports are strictly defined, administrative burdens have increased, information gaps abound, changes are constantly being made, and critical information is not available in a timely manner.

To the extent it is a market, this is reflected in service closures, workers leaving, business mergers, and less choice and control. Unless service providers are given the freedom to decide which services they want to offer, to price those services, and to test whether they can sell their product in the market at the price they ask, the NDIS won't produce efficient market-based outcomes and won't work for provider organisations.

Through the looking glass: testing the new world of the NDIS



Rachael Scott is Program Manager Mental Health Community Support Services at cohealth

Like Alice heading into Wonderland, service providers and consumers of mental health services are about to travel into a new world, the National Disability Insurance Scheme (NDIS), and it is a world we do not fully understand yet. NDIS will challenge our perceptions of place and purpose and adventures will abound ... well at least that is how it may feel.

The national roll-out of the NDIS from 1 July is creating opportunities to dramatically change the way service providers do business. It is also providing consumers with more control and flexibility in the way they receive services.

With this in mind cohealth has spent the last year testing new approaches to the design of our activities and the method of delivery. This article shares some insights that we have gained along the way.

Preparation and principles

There are a number of things we know will occur through the NDIS, namely:

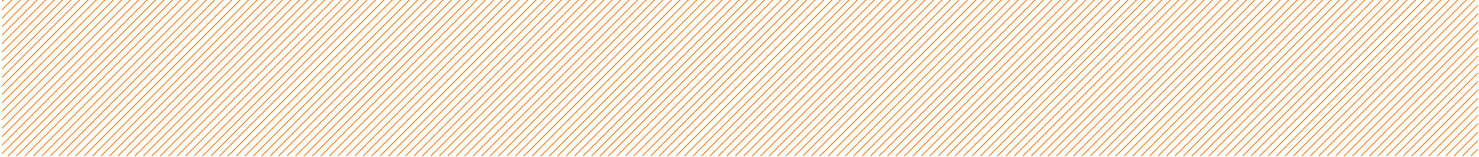
- consumers will receive services as outlined in a plan that will be developed with their direct involvement
- consumers will get a choice of approved providers who will deliver the services outlined in the plan
- mainstream service providers may also be part of the mix in meeting the defined needs of consumers.

With these new requirements in mind, cohealth reworked its Mental Health Community Support Services service model to test some of these assumptions and prepare consumers and staff for the new way of working. To assist with this, cohealth 'quarantined' some of its funding to purchase services outside of cohealth's offerings. These 'purchased CSUs (consumer service units)' would be used to buy services from specialist or expert services outside of our organisation and to appoint coaches to work with consumers on developing a plan.

Our coaches used cohealth's recovery model, which is underpinned by the Collaborative Recovery Model developed by Wollongong University. Using this, consumers work alongside their coach to plan for a life that is positive and possible by exploring what is a meaningful life to them.

As they go through this process, they actively consider and pursue opportunities for mainstream support and participation, in order to achieve a broader and more sustainable experience of their vision. We understand that sometimes big issues require small, targeted, expert interventions from outside mental health services, even if they do operate in the private sector; and in a timely way, that allows for a more flexible and individualised approach. This approach also assists consumers to experience greater connection with the world around them without the stigma of accessing a 'mental health service' – yet still with the comfort of this interaction being negotiated with someone who understands.

Services within the community sector can be hard to access for people who are unwell and/or need flexibility both in access and time. Some mainstream services can be more flexible – for instance, working outside of normal 9 to 5 hours or being mobile and able to meet the consumer in the community or home. Partnering with services that can provide flexible support in this way allows our coaches to focus on the tasks they specialise in, without merging into roles that can be sourced elsewhere.



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Testing the model

The story of Peter* provides one example of the model in action. Peter had accessed mental health services for several years as he experienced severe anxiety and depression. He held strong beliefs that the government was spying on him, his phones were tapped and there was a conspiracy to 'get' him. As a result Peter rarely left the house and was isolated. He reported that he felt lonely and frightened 'all the time'. Peter's physical health was compromised due to his inability to lead a full life.

After a coaching discussion with his worker Peter disclosed he had ten outstanding tax returns. To address the issue, cohealth partnered with a tax agent who completed and lodged the forms. Peter's coach was present during the one meeting needed to fill out the forms. To deal with the small fine that resulted, the agent negotiated a payment plan of \$10 a fortnight. As a result Peter felt less anxious and was willing to discuss accessing groups and making other changes to his life. The tax agent will now contact Peter each year to complete his tax forms. cohealth will not play a part in that future relationship.

Historically staff would have donned their professional begging hat and looked for a 'free' agent or a donation of time from a professional. This is a cumbersome and time consuming task and, given the small window of time available in the process of preparing a plan, it was much more effective to be able to access professional advice immediately.

Anne* provides another illustration of the model at work. Anne has a complicated life and was seeking a legal service that would act on her behalf to pursue a civil action relating to events from her childhood. The legal service informed our staff member that they would not act on her behalf as they were not convinced she was 'well' enough to be able to instruct them. This decision added to her anxiety and she began to self-harm. Anne could not afford counselling supports let alone pay for legal representation. She faced a waiting time of up to a year for community services that could assist.

Along with specialised counselling, cohealth was able to source and paid for a private provider to conduct assessments to determine her capacity to give legal instructions, as the community services waitlist was up to one year for this service. **The assessment then informed the next stage which allowed for her to have closure by creating the capacity to follow through with her right to justice.** This ability

to step outside of the usual service paradigm and deliver an immediate response provided a circuit breaker for Anne that **resulted in maintaining her safety and the realisation of her legal rights.**

As these examples show, the model involves cohealth partnering with numerous mainstream service providers, both formally and informally, to deliver creative individualised responses to consumers' goals. Rather than keeping service delivery in house we use resources that are available to all members of the community to skip queues, assist with hoarding, integrate services, access education, link into mainstream recreational activities, support tax returns, book into dog training and so much more. Understanding that providers may have little experience assisting people with mental health challenges, cohealth supports providers in the mainstream world to become more accessible to consumers.

How it's worked to date

Feedback from staff about the new service model was positive. Staff felt as though their skillset was being used in an optimum way without distilling their expertise to 'coffee and chat' scenarios that assisted the consumer but did not change the way they lived. It also allowed for appropriate expertise to be accessed in more complicated scenarios via private providers with shorter waitlists. The ability to act on consumer need in a timely manner was also identified as a crucial benefit.

While accessing mainstream service providers has been mostly positive, there are times when it has not gone to plan. One example is with 'off the rack' cleaning/gardening agencies that are contracted by consumers to help them at home. We have learned that our coaches need to be present when these services attend, to support consumers to speak up so that they get the services they need. Also these types of services are very transactional in nature and so can be delivered in a cursory and dismissive way. This can be challenging for consumers when it involves their home environments, places that are often their 'safe haven'.

cohealth will continue to test the assumptions of the NDIS model for mental health consumers. At first glance it appears to be positive, but there are some areas that need work. In the new world of the NDIS, careful consideration is needed about who provides services for some of our more vulnerable consumers, and that takes time and planning.

* Names have been changed for privacy reasons

The emergence of local peer hubs across Victoria – outcomes and future directions



Cassy Nunan is Consultant, Consumer Advocacy and Leadership at Wellways

Peer hubs, also known as peer networks, have recently emerged in a number of regions across Victoria. Peer workers from clinical and community services attend these forums to access collegial support, share information, de-brief practice challenges and utilise reflective practice to improve skills.

Workers attending peer hubs include those in 'family/carer' peer roles, and those in 'consumer' peer roles. Four peer workers from hubs in the Grampians, the Great South Coast, the Mornington Peninsula and Melbourne's East, report that peer hubs are proving to be an enormous resource in supporting peers to develop confidence, practice competence and workforce connectedness.

What is peer support work?

Peer support is most often described as a process of drawing upon wisdom gained in recovery, to offer role modelling, support, information, and useful strategies for others on the recovery journey (Gates & Akbas, 2007).

Recovery involves being able to 'make meaning' of what has happened, reconnecting with social roles and community, and forming renewed and empowered identities (Leamy et al., 2014). It also requires the development of confidence and skills to resist stigma and discrimination. Peer workers, by 'having been there' and 'walked the talk', have a unique role in walking alongside people to support their recovery journeys.

The evidence points to peer support having profound outcomes for service users, including reduced hospitalisations, increased hope, confidence and empowerment, and building job skills to move towards career ambitions (Moran et al., 2012).

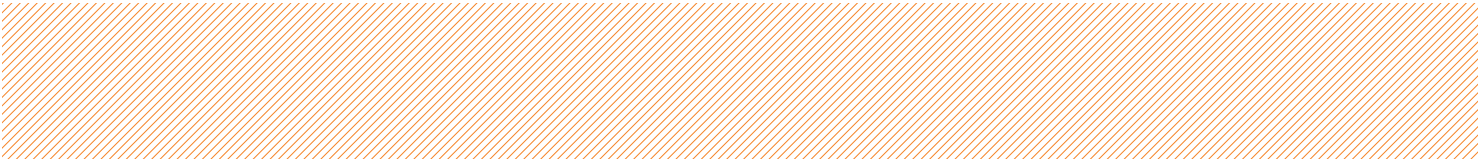
In the last six years community and clinical mental health services have witnessed an enormous increase in peer worker roles, along with the endorsement of such roles by government funded programs, such as the Personal Helpers and Mentors Service, and government recognition of the value of peer roles. In 2013, the Commonwealth Framework for Recovery-Oriented Mental Health Services stated that mental health organisations must recognise the value of peer workers and commit to resourcing and supporting the peer workforce:

Recovery is a vision and commitment shared at all levels of an organisation. The vision is sustained by a diverse, appropriately supported and resourced workforce that includes people with lived experience. It includes peer-run programs and services (2013, p. 17).

Challenges in peer work

Government allocated funding for peer roles is scant. However, the majority of Victorian service organisations have embraced this vision and devised ways to employ peer workers – often utilising funds that would normally be allocated to non-peer positions.

As a consequence, many peer workers find themselves having to comply with non-specific position descriptions. This can create a lack of clarity for peer workers and confusion for other team members. In these contexts, peer workers can struggle to work in a genuinely peer oriented manner, sometimes assuming responsibility for intuitively



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formulating ways of working that seem a 'best fit' within teams. Across the sector, diversely defined peer positions have resulted in the emergence of disparate roles and inconsistent practices. The development of parameters for peer positions and frameworks for training and support is essential to ensuring a cohesive and highly effective peer workforce in Victoria. Equally important is structural and cultural change within organisations to ensure that peers are treated as equals and respected for the value of their work.

Peer workforce development challenges are not unique to the Victorian experience. International literature about peer support work indicates that while peer work is tremendously beneficial, workers face the following tensions:

- lack of infrastructure and accommodations
- unclear job description
- lack of support for peer roles
- insufficient training
- maintaining the peer worker's distinct practice approach
- role isolation (i.e. being the only person in a region in a peer support role)
- difficulties maintaining boundaries with participants
- challenges maintaining self-care
- low confidence in the role
- other staff not understanding the role
- stigma in teams (other staff devaluing the role)
- feeling stressed and overworked (Repper & Carter, 2011; Moran et al., 2012).

The role of peer hubs

Shery Mead, who conceptualised the Intentional Peer Support approach states:

If we can establish the same parameters for all of peer support, it will support peers working in the service delivery system with a unique and fully distinguishable framework for thinking (Mead & MacNeil, 2004, p. 7).

In some regions of Victoria, peer hubs have developed as both grassroots and sectoral responses to some of these challenges. Anecdotally, these networks are providing much needed support and validation for peer workers, and a space where roles and practice approaches can be discussed in forward-thinking ways. In some areas, peer hubs have been established through service alliances, Primary Health Networks and partnerships between clinical and community services. Some hubs have received seed funding to become established while others have relied on support from peer workers' respective organisations.

Broadly speaking, peer hubs focus on providing a space for:

- mutual support
- professional development to ensure rigour and affirm the integrity of specialised peer work roles
- co-reflection, as a process for formulating practice strengths
- debriefing difficulties in relation to utilising lived experience, to get support and to reflect on self-care approaches
- discussions about workplace co-option challenges, stigma and discrimination – and reflections on strategies to address these
- networking, practice synergies and updates.

Snapshots from Victorian peer workers

Peer workers from four Victorian regions have each provided a snapshot of the functions and outcomes of hubs that they attend.

The Grampians Peer Network (by Rick Corney from Wimmera Uniting Care)

The Grampians Peer Network was formed in mid-2014 by a MIND peer worker who had received backing from his management. The network's membership is comprised of consumer consultants, peer workers and carer consultants from Wimmera Uniting Care, Ballarat Health Services, MIND, ACSO, Wellways and Grampians Community Health, who are supported by employers to attend bi-monthly meetings.

The network provides a space for peers to build relationships, learn about each other's roles and offer support. It's a confidential environment for discussion, and workers take ideas or information back to their respective organisations. The network is not funded. Challenges faced by the network include the vastness and diversity of the region (40,000 square kilometres) and finding suitable locations for meeting that limit travel time. The network hopes to expand membership and to assist in the establishment of similar networks in other regions.

Great South Coast Peer Network (by Darren Dorey from South West Health Care and Wellways)

The Great South Coast Peer Network developed with the support and backing of organisations employing peer workers, with recognition of the needs of the relatively new workforce. Mutual professional support proved helpful in formulating ways to deal with challenges that employers had not yet perceived. Membership comprises 11 workers from four organisations: Wellways, Acso, South West Health Care Mental Health Services, and Brophy.

The network focuses on professional development, reflective practice, peer to peer support and debriefing. Members claim that the greatest benefit is being able to share experiences and challenges, without fear of repercussion, and without feelings of inadequacy that sometimes occur in the workplace. Due to the tyranny of great distances, and the largely part-time nature of member roles, it is difficult to decide on meeting times and premises that suit most. Currently the network is not funded and lacks clarity from employing organisations about the types of support they are prepared to provide. The network plans to continue providing mutual and professional support, and adapt to meet the needs of a growing workforce. There is a view to introducing professional development pathways and find funding to support the network's activities.

Eastern Peer Support Network, Melbourne (by Paula Kelly, from Eastern Health)

The network was formed under an alliance of both clinical, community mental health and alcohol and other drugs (AOD) eastern regional stakeholders, to respond to the need to support and foster the development of the eastern peer workforce. Pilot funding to establish the network was provided by the former Medical Local (now Eastern Melbourne PHN). The network includes carer and consumer peer workers, and works in partnership with peak bodies such as Victorian Mental Illness Awareness Council (VMIAC) and the Self Help Addiction Resource Centre (SHARC).

The network was co-designed to meet the needs of members, including workforce development, peer to peer support, and knowledge about service providers in the region and networking opportunities with likeminded people. Members are mostly 'siloed' lone workers in services, and have found great value in connecting with peer colleagues. The network has identified a number of workforce gaps, such as: the availability of peer to peer supervision, reflective practice opportunities, as well as training and education that supports employment pathways. Members have become aware that there are a large number of people who use lived experience in non-designated peer roles. Further, non-peer workers in the sector seem to have very little knowledge about the roles and benefits of the peer workforce.

Peninsula Peer Hub (by Sherie Stiefeler from Mentis Assist)

The Operations Manager of Peninsula Health invited clinical and community mental health services to form a working party, with the view to establishing a peer worker network on the Mornington Peninsula. Management of organisations recognised the need for

a formal network of peer workers that would enhance the professional capacities of peer workers and provide a forum for information and knowledge exchange. One off funding was provided by the Medical Local.

Consumer and carer workers and volunteers from clinical and community services attend the hub, and membership was extended to peer workers in the AOD sector. The hub is utilised by peers to undertake reflective practice and focus on professional and workforce development. Its vision is to develop innovative service delivery in the Peninsula region.

Reflections

Local peer hubs have emerged in a number of areas across Victoria. For members, these provide a valuable space for reflection about the roles peer workers play within the current service system context, and opportunities to envision a future for the workforce. Most peer hubs actively focus on practice development, peer to peer support and information sharing. Within these spaces, peer workers have derived significant benefits from connecting with each other about unique challenges that are often not recognised, with a view to solutions. The dedication and diversity of consumer and carer lived experience has generated significant learnings, with flow on benefits for partner organisations and participants.

Peer hub members believe that other regions could derive similar benefits by forming hubs and drawing upon accumulated knowledge of what works. Further, the establishment of state-wide linkages between networks would provide an invaluable opportunity for knowledge exchange and the development of collaborative and innovative peer models.

There is great potential for outcomes at a state-wide level, if the peer hubs' grassroots experience and acumen is harnessed, in service of unity and uniformity of values. This could shore up the integrity of the Victorian peer workforce, and ensure relevance and viability during this era of reform. The hub members who contributed to this article agree that this sort of initiative would only be achievable with sector wide support and operational funding.

At the organisational level, more work needs to be done in regard to implementing frameworks that ensures the professionalisation of this emergent discipline, and attends to matters of equality and equity in workplaces.

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The use of Trialogue in mental health settings



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The use of the Trialogue three-way conversation method presents a unique intervention and opportunity to address topical and sometimes difficult issues that involve consumers, families/carers and practitioners as key stakeholders in mental health service settings.

The practice of Trialogue resonates strongly with the notion of co-design, as it brings together these stakeholders in a respectful and informed environment to acknowledge, share and explore the different voices and perspectives.

In this article I will firstly provide a brief history of Trialogue and description of its underpinnings in the notion of the dialogic. Secondly, an outline of the Trialogue practice model developed by the Bouverie Centre will provide a sense of its general application. Thirdly, I will explore its possible uses in local mental health service settings.

From Dialogue to Trialogue

Since the late 1990s the Mental Health program at the Bouverie Centre has hosted Trialogues in the form of free forums and regular mini conferences with positive evaluation from the many participants. The Centre has also run Trialogues on focused topics in mental service settings. Coincidentally, a practice of Trialogue also emerged in Europe during the mid-1990s after the World Conference for Social Psychiatry in Hamburg in 1994 by a small group of people representing services users, relatives and professionals. This gave birth to what is now known as the 'Vienna Trialogue' (Amering, et al. in Lefley & Johnson, 2002; Amering, 2010).

One of the key international supports for the use of Trialogue has been the World Health Organisation's recommendations on best practice in working with service users and family carers (Wallcraft et al., 2011). At the local level, Trialogue reflects the now well understood evidence that wellbeing and positive outcomes for consumers and carers is

improved when family and carers are included in all aspects of the ongoing care of a person with a mental illness (Chief Psychiatrist Guidelines, 2005).

For understanding the roots of the Trialogue, I have turned to the sociologist Richard Sennett, who was inspired by the philosopher Mikhail Bakhtin. Sennett places the dialogic at the centre of his investigations into the rituals, practices and sentiments that make or break 'cooperation' (Sennett, 2012). He proposes that the dialogic conversation requires "listening carefully – developing attention and responsiveness to the other."

Sennett notes that while "no common agreement may be reached through the process of exchange, people may become more aware of their own views and expand their understanding of one another." He identifies other key features of conversation such as: curiosity, empathy more so than sympathy, being open to complexity, reflecting on and learning about/from others, more awareness and development of our own view, communication which addresses ambiguity, conversations about difference and 'sitting' with differences (Sennett, 2012).

Sennett contrasts the dialogic conversation with the dialectic conversation: the first is a bouncing off of views and experiences in an open ended way, the second, a play of contraries leading to agreement. He argues that in a dialogic conversation misunderstandings can eventually clarify mutual understanding without the necessity for agreement.

Triologue is not specifically a problem solving model, although it can lead to *identifying, clarifying and investigating* problems through understanding the different perspectives and positions.

Triologue in mental health settings

People's capacities for cooperation are far greater and more complex than institutions allow them to be (Sen & Nussbaum, 1993).

The Triologue as a three way conversation aims to bring together the perspectives of consumers, family members/carers and mental health practitioners. It provides a facilitated safe space to reflect on relevant, topical, key and difficult issues (often difficult to discuss and openly acknowledge) in mental health service settings. In creating a Trialogic space, we raise for examination those issues that are not talked about in public mental health, that we might take for granted or that might not be aired in other forums, perhaps because they are perceived as possibly emotive or conflictual. Issues that have featured in the Bouverie mental health Triologue mini-conferences have included:

- *Insight: losing it & using it! Psychiatric symptom or differing views about what's wrong.*
- *Risky business: exploring the risk of self-harm to self and others.*
- *Where does the hurt go: emotional responses to harm, threat & loss in mental illness.*
- *The power of the State: exploring how perceptions of 'state of mind' and consequent intervention by 'the state' affect relationships in mental health.*
- *'Did you hear about Fred?... they said he had a breakdown': exploring the role of shame and stigma in the lives of individuals, families and workers dealing with mental health difficulties.*
- *Doing hope and dealing with despair: the role of hope and despair in the lives of individuals, families and workers dealing with mental health difficulties.*
- *Non-compliance: exercising personal power or courting disaster.*
- *Roles, relationship & intimacy in mental illness: an exploration of changes in intimacy, relationship roles when someone is affected by a mental illness.*
- *Caring, cared for & carer: exploring the interpersonal, professional & political consequences, both positive and negative, of the terms used to describe the roles of giving and receiving care.*

Using Triologue, we explore the issue/topic in a way that creates the possibility for participants to be able to reflect upon and gain insight into their and others' experience and perspective. This provides added depth and richness to the experience for all participants. This also creates the possibility for shifts in understanding and responding and can establish 'a common language' and promote a 'culture of discussion' as a basis for working together effectively.

Triologue, for example, can provide an opportunity for consumers, carers and practitioners to share their experience more directly; for practitioners to reflect more deeply on their practice alongside the people with whom they provide a service, for all stakeholders, to explore how the system constrains or impacts upon them. Formulated in dialogical terms, these types of conversations can contribute to new insights for all.

Triologue is not specifically a problem solving model, but it can be the beginning of a process to address problems. It is also contrasted with a dispute resolution model, by not needing to reach resolution in a dialectical manner (discussed above).

The two important outcomes of Triologue are that it shapes a space that enhances realistic, honest and inclusive ways to communicate and inform as well as offering all stakeholders greater and equal opportunity to actively participate and contribute.

Triologue Practice Model

The process of creating, structuring and supporting a Triologue requires thoughtful planning. Preparation must go into providing the scaffolding required to protect the safety of all participants, but which simultaneously challenges them to openly share their experiences and perspectives. Here are the steps we have developed:

Phase I – Preparation

- Creation of a Triologue working group.
- Identify a topic/issue that is suitable for the Triologue approach.
- Develop the topic proposal and draft possible questions to prompt conversation.



Dialogue provides an opportunity for practitioners to share their experience more directly as people who both influence and are influenced by the lives of carers and consumers....

Phase 2 – Participants

- Identify and invite participants (each role or position can have one or a number of representatives, but with all three roles having equal numbers).
- Brief participants on the topic and process; ask for feedback and input to draft 'prompt' questions; respond to any issues or concerns.

Phase 3 – Session outline

- Brief presentation of topic (facilitator).
- Introduction of each participant by the facilitator.
- Brief overview (3 minutes) by participants of their position and view/reflections on the topic (e.g., using hopes and aspirations inquiry format).
- 'Prompt' questions posed by facilitator inviting panel/participants responses and encourage conversation between participants.

Phase 4 – Session conclusion

- Invitation by facilitator for a brief reflection from each participant on:
 - » *What were the main themes that struck or resonated with them that emerged from the Dialogue conversation?*
 - » *What might they take away from the session: What has it got them thinking about? What might they now consider that they hadn't considered before? What might you continue to support?*

In thinking about conducting a Dialogue in a local service setting, the three key questions we may ask ourselves would be:

1. *In what situations do you think it would be helpful to conduct a Dialogue?*
2. *What issues/topics do you think would be good to explore through a Dialogue?*
3. *What would you need to set up a Dialogue?*

Conclusion

This article has set out to introduce the notion and practice of Dialogue and its use in mental health settings. Strongly resonating with the idea of co-design, Dialogue brings together the key stakeholders of consumers, carers and professionals in a respectful and dialogically informed environment to acknowledge, share and explore their different voices and perspectives.

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#TowardsRecovery

This year **VICSERV** worked with **Croakey**, which provides in-depth online health journalism, to support the communications around the conference.

They led the conference live tweet, using hashtag #TowardsRecovery which led to 495 participants, both at conference and beyond, creating 2,248 tweets. This led to tweets with the #TowardsRecovery hashtag being seen 8,296,952 times.

Croakey interviewed our keynote speakers and a number of other conference participants as well as writing a number of newspaper pieces on conference.

All Croakey content is available via the Conference website conference.vicserv.org.au



Tweets with the **#TowardsRecovery** hashtag were seen

8,296,952 times



Crackingly-good #TowardsRecovery conference. Well done @MsKKoop & @VICSERV team.

@bedrocksocialco





Citizenship = everything it means to be a true equal says Dr Simon Duffy
#TowardsRecovery

.....
@JackieVanVugt



Seeing the person and not the diagnosis is the key to community inclusion #TowardsRecovery
<https://t.co/iyG4PNXoo>

.....
@MaryJSayers



Peer Power People with mental health transforming lives & community #TowardsRecovery

.....
@simonjduffy



@VICSERV #TowardsRecovery
#chillinginabeanbag during the morning tea break.
Nice touch VicServ. A bag for home may be in order.

.....
@lisafelmingham



Stop by @cohealth_au 's advocacy tree to share your thoughts on mental health.
#TowardsRecovery @MsKKoop

.....
@VICSERV



MC Peter Mares multi-tasking like a boss as he encourages #TowardsRecovery delegates to take and tweet a selfie with a message of hope.

.....
@wepublichealth



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
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