

# View

## from the Peak

### Mental Health NGO Learning and Development Unit - Timely.

#### EXECUTIVE OFFICER REPORT

*Jenna Bateman*

It never rains but it pours – opportunities for NGOs working in the mental health sector at the moment are better than they have been in a long long time. There are currently several opportunities through the Council of Australian Governments (COAG) and NSW Health. The successful tenders for the second round of the Family and Carers Support Program have just been announced; announcement of successful tenders for Housing Accommodation Support Initiative (HASI) Stage 4 should happen very soon as should those organisations successful in obtaining funds through the Mental Health Non-Government Organisation (NGO) Infrastructure Grants Program. At the national level through the COAG process, The Australian Government Department of Families, Community Services and Indigenous Affairs (FaCSIA) tenders for the Personnel Helpers and Mentors Program have been requested as have tenders for the Department of Health and Ageing (DoHA) Day to Day Living Program. Whilst no-one is complaining about the confidence being shown in what NGOs can achieve, how the workforce can support these new programs is obviously an issue.



It is very timely then that a Learning and Development Unit (LDU) has recently been established by MHCC in partnership with NSW Health in recognition of the need for sector training to reflect evidence on what are currently considered to be positive approaches and ways of working with people living in the community who have mental health problems.

The funding of an LDU specifically to enable NGOs working in mental health to access appropriate training and learning is a major step in recognising the valuable role the sector has and can play in improving the mental health of the community in this state.

Ideally, the work of the sector and the training that supports it should be based on research evidence of what has been shown to be effective in improving the quality of life of consumers and carers.

The evaluation of the HASI and evidence of the substantial benefits that program delivers for people fortunate enough to

access it has meant increased understanding of and confidence in just what NGOs do and why they should be supported to do more.

Whilst many individual NGOs have been clear about the evidence base driving their approach and service delivery model, it has been generally accepted that substantial evaluation across a range of models has been lacking, largely because of the resources required to undertake such research.

MHCC has been aware that the evidence base for the work of the sector is disparate and difficult to access. With this in mind we commissioned Jonine Penrose-Wall to bring the evidence so far, together in one document. Like many things this was far more complex than initially conceived and required a great deal of sifting through material with levels of evidence ranging from anecdotal support in a range of published papers to full randomised control trials. The document titled "Working on Strengths" is now complete and is a thorough exploration of the international literature on models of care in our sector.

'Working on Strengths' is a highly academic piece of work that demonstrates where our sector is in terms of developing its evidence base. The document allows us to see where the gaps in evidence lie and the extent to which the undertaking of research can lend legitimacy to or dictate what is profiled and supported and what fails to get a mention. It also allows us to get a better idea of which research methodologies capture the work of our sector and which fail to do it justice.

'Working on Strengths' is an important piece of work, which sits alongside other recent MHCC initiatives being undertaken as part of the NGO Development Strategy. It is specifically linked to the work being done on outcome measurement and data and information management designed to support the sector to produce evidence of good practice, quality initiatives and service reorientation. 'Working on Strengths' can be found alongside this related work in the NGO Development Strategy section of our website. [www.mhcc.org.au](http://www.mhcc.org.au)

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# count me in

Innovative community  
based approaches  
to better mental health

**As the name implies, everyone is welcome to the 'Count-me-in' NSW NGO Mental Health Conference.**

The Mental Health Coordinating Council, in partnership with the Mental Health and Drug and Alcohol Office, is facilitating the 2007 NSW NGO Mental Health Conference. NGOs working with people who have mental health problems provide a diverse range of professional and innovative service approaches designed to build resilience and assist people in their recovery process.

We know that mental health is about social inclusion. But working in the mental health sector, we grapple with the question of how social inclusion for all can actually be enabled in practice. It is not only about inclusion in the planning and delivery of the services needed for better mental health. It is about creating a community that is open and welcoming to all people living with mental illness, a community that includes and values all people as one of its own. People living with mental illness need to have a socially valued place, a real sense of entitlement and citizenship within society, and a feeling of belonging.

It is therefore clear why 'Count Me In' is our conference theme. 'Count me in' – I would like to be included. And 'Count me in' – I will include you.

Our conference will be formally opened by Her Excellency the Governor of NSW, who has endorsed it with the words: "I give my support with a sense of optimism and hope to [the] very valuable endeavour" of social inclusion.

We are delighted to have two respected spokespeople in the field of social inclusion as our day one keynote speakers, Jill Whitehorn (Social Inclusion Unit, SA) and Janet Meagher (consumer spokesperson). Each will talk about the importance and key aspects of social inclusion, and some of the ways in which this might be achieved. Closing the program is Eva Cox, who will address the implications of 'social inclusion' for third sector activism.

We have an exciting line-up of speakers, and some great presentations describing some of the innovative and dynamic work occurring within the mental health NGO sector in NSW. We hope you can join us, and count yourself in. Following is a snapshot of the program highlights. Please refer to the MHCC website for the full program.

## Speakers

Some of the diverse speakers at Count-Me-In include: Jenna Bateman (MHCC), Michelle Burrell (NCOSS), Cherie Burton MP, Merinda Epstein (consumer advocate), Melissa Gibson (Department of Housing), Peter McGeorge (St Vincent's Mental Health), Clover Moore MP (Lord Mayor of Sydney), Mary Perkins (Shelter NSW), Larry Pierce (Network of Alcohol and Other Drug Agencies), and Michael Raper (Welfare Rights Centre, Sydney).

## Symposiums

We will hold four dynamic symposiums, which will bring delegates together to hear current views and innovations and participate in panel discussions. The symposiums will cover four of the main aspects of social inclusion in mental health: the work of NGOs, consumer participation, sustainable housing, and employment.

### *'In from the margins' – NGOs working for mental health*

Mental health consumers are finally being understood in ways that pay due attention to every aspect of what is required to live a fulfilling life. Whilst NGOs have always understood the need for a whole of life approach, severe under-funding has prevented the sector developing the sort of infrastructure needed to demonstrate the value of its work. This symposium will describe the changes underway within the mental health system which allow the potential of community based approaches to better mental health to be realised.

### *'How hard can it be?' Consumer Participation*

Mental health has often been hailed as taking the lead when it comes to consumer participation. However, the complexity of the issues facing consumers as they take their rightful 'seat at the table' is threatening that position. The consumer movement is struggling with issues of leadership, role confusion, tokenism and inconsistent and ad-hoc policy development. This session will highlight some of the difficult to negotiate areas within consumer participation and invite comment from the floor.

1st – 2nd MARCH 2007

### *'In from the cold': The housing landscape*

The housing sector can seem like an impenetrable maze to those not directly working within it. This symposium aims to provide a broad picture of the housing landscape incorporating affordable, public and community housing. It will explore the implications of current Dept Housing policy directions for people with mental health problems in ensuring tenancy maintenance and suitable housing inside and outside the human services system.

### *'Is it working? Employment in today's climate*

The employment landscape has changed markedly since the introduction of two significant pieces of legislation, Welfare to Work and WorkChoices. Achieving and sustaining meaningful employment is crucial to the recovery process for many consumers. This symposium will look at the challenges that exist for consumers in the current welfare and employment environment, as well as some of the work that NGOs are doing to support consumers within this context.

### Concurrent Sessions

A wide range of organisations working in mental health will present innovative, thought-provoking and practical ideas on mental health with a focus on the conference theme of social inclusion. Papers and workshops will be presented in the following streams over two days. At each session, there will be opportunity for questions and discussion. Topics include:

#### DAY 1:

'Let's talk' – Partnerships that work

'Size isn't everything' – Third sector challenges

'More than a roof' – Critiquing accommodation support

'Where's the justice' – Exploring mental illness and prisons

Practice snapshots

#### DAY 2:

'Collaboration and Innovation' – Mental Illness & Substance Abuse

'Somewhere to call home' – Exploring homelessness

'Your idea or mine?' – Consumer recovery

'Different strokes' – Valuing diversity

Practice Snapshots

# NSW NGO MENTAL HEALTH CONFERENCE SYDNEY MASONIC CENTRE

### Sponsors

We are very thankful to our sponsors who have shown a strong interest in the 'count-me-in' conference aims, and made the conference possible. We thank: North Coast Area Health Service, City of Sydney, Cancer Council of NSW and Community Sector Banking.

### Where and when

'Count-Me-In' will be held in Sydney at the Sydney Masonic Centre (66 Goulburn Street), a short stroll from both Museum and Central Stations. The Wilson's parking station is diagonally opposite the building and costs \$4 per hour, with all day parking for \$40 per day. For a cheaper day rate try Central Square Car Park on the corner of Hay & Pitt Streets: \$25 all day, but get in early.

The final conference program and registration forms are available at  
[www.mhcc.org.au](http://www.mhcc.org.au)  
or contact: MHCC Ph: 02 9555 8388 x0 Fax: 02 9810 8145 E: [info@mhcc.org.au](mailto:info@mhcc.org.au)

# New money for wish-lists

MHCC is pleased to administer the new Infrastructure Grant (IGA) Program funded by NSW Health. It is a welcome opportunity for mental health funded NGOs to develop some of the projects on ever-growing wish-lists. John Hatzistergos, Minister for Health, announced a \$2 million allocation to the IGA Program, providing a significant opportunity for NGOs to improve the quality of existing services and progress towards accreditation with nationally recognised service standards. Projects funded under the IGA Program will be monitored by MHCC, and completed by December 2007.

The December/ January period was busy for MHCC as it needed to implement the IGA Program as soon as possible. A consultant, Edwina Pickering, was engaged to develop the grant process. An Expression of Interest was widely advertised in early December 2006, and by the closing date of 25 January 2007, 29 NGOs had submitted applications for 32 proposed projects.



Many NGOs took the opportunity to identify infrastructure improvements, and the diverse range of projects included –

- Upgrading premises, e.g. painting, carpeting, and air-conditioning
- Purchase of office equipment, e.g. photocopiers, vehicles, computers, and software
- Employment of temporary staff or consultants for projects such as: assistance with progress towards accreditation, development of new strategic planning, review of policies and procedures, training for staff and Board members, improvement of data analysis systems, and/or accessibility for ATSI consumers.

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MHCC convened an assessment panel including NSW Health, community sector and consumer representation. Successful NGOs were immediately recommended to the Minister for Health to avoid potential delays relating to the forthcoming NSW election. In a small number of cases, the panel is seeking supplementary information about the proposed projects before finalising assessments. The outcome for all applications under the IGA Program will be announced soon.

Although fewer applications were received than expected, MHCC considers that this is due to the tight timeframe over the Christmas/ New Year period and the newness of the initiative. It is likely that many more mental health NGOs will take up the offer to apply when a second round of funding (we are hoping) will be announced shortly.

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# NSW State Election Policies at a Glance

IN THE LEAD UP TO THE NSW STATE ELECTION (MARCH 24TH)  
TAKE A LOOK THE MENTAL HEALTH POLICIES OF EACH OF THE MAJOR PARTIES.

## NSW LABOR PARTY

The NSW Labor Party policy on Mental Health is contained in their June 2006 document - A New Direction For Mental Health. This 5 year \$939 million package provides a significant boost to a range of mental health programs across government, with a new emphasis on community care. Key expenditure includes:

- \$102 million for prevention, promotion and early intervention
- \$712 million to improve and integrate the care system
- \$114 million for enhancing participation of people with mental illness in the community
- \$11 million for workforce development programs.
- \$58 million more for the Housing and Accommodation Support Initiative (HASI).
- \$51.4 million for out of hours' emergency and acute community responses.
- \$6.5 million for improved support for people with a mental illness in the criminal justice system.
- \$28.6 million for tertiary treatment services for young people
- \$17.6 million for a co-morbidity package (mental illness and substance abuse)
- \$13.5 million to Non-Government Organisations to support families and carers.

In 2006/07, the NSW Government will provide a record dedicated mental health budget of \$946 million – an increase of \$93 million or 10.9 per cent on the 2005/06 budget.

## NSW DEMOCRATS

NSW Democrats regard Mental Health as being equally important to physical health and believe that it deserves equal priority in public health policy.

On the 11th December 2001, NSW Democrat MLC, Dr Arthur Chesterfield-Evans successfully established a Select Parliamentary Committee inquiry into Mental Health. The inquiry looked into the changes which have taken place since the adoption of the Richmond Report and resulted in raising public awareness of mental health and increased funding for mental health. While the Democrats are proud of this achievement, issues surrounding workforce shortages, unmet need in the community support sector and forensic patients still remain and will be priorities for the Democrats if re-elected to NSW Upper House.

The Democrats will continue to push for the implementation of all the Inquiry's 120 recommendations, especially in the areas of:

- Establishment of an Office of Mental Health in the NSW Premier's Department
- Co-ordination of services across government and the NGO sector
- Increases in supported accommodation
- Data collection on readmissions to psychiatric units
- Additional resources for community crisis teams.

## NSW LIBERAL NATIONAL PARTY

If elected the NSW Liberal National Party promise to commit an additional \$396 million to the current mental health budget. This money will be used to fund:

- 150 new community mental health caseworkers
- 150 additional supported accommodation places
- Revamping of Rozelle Hospital at Callan Park, providing up to 400 places

The NSW Liberal National party is also committed to appointing a Minister for Mental Health. This has not previously been done by any NSW government. The party also expresses a firm commitment to work hand in hand across agencies and in partnership with other levels of government and non-government organisations to deliver the best level of continuous care.

Another priority for the NSW Liberal National party is to further review and reform the Mental Health Act, to achieve improved mental health outcomes for the community, including better recognition of the role and responsibilities of families and carers.

## NSW GREENS

The NSW Greens are placing a high priority on mental health in their preparation for the State election. The following initiatives form the basis of their Mental Health Policy.

- Significant increase in funding for mental health, including public hospital inpatient services, community based services, supported accommodation, mental illness and substance abuse services and research, support and respite for families and carers
- Improve and integrate hospital and community-based mental health services;
- Provide appropriate mental health treatment in public health facilities and in prisons;
- Increase resources for community based services providing mental health early intervention programs;
- Ensure that people who are drug and alcohol dependent are primarily regarded as clients of the health system rather than the criminal justice system;
- Support the development of innovative and targeted mental health interventions;
- Recognise and address the special needs of refugee, temporary protection visa (TPV) holders, and other displaced persons;
- Additional funding to allow the provision of mental health services within schools.

*At the time of printing the above information is what the Parties were able to make available to MHCC. Visit their websites for more information.*

# Mental Health Act review



Following the recommendation of the Dec 2003 *Select Committee Inquiry into Mental Health Services in NSW*, in 2004 the Minister announced a comprehensive review of the Mental Health Act 1990. After an extensive series of consultations the Bill was finalised, excluding the Forensic Provisions of the Act.

Two discussion papers were released, *Carers and Information Sharing* (February 2004) and the *Operation of the Mental Health Act* (August 2004). Over 200 submissions were received by government. At every stage of the process, MHCC facilitated working groups, consultations and forums and produced relevant, targeted submissions. All of these are available on the MHCC website at [www.mhcc.org.au](http://www.mhcc.org.au)

## Mental Health Bill 2007

The Exposure Bill, which was the draft legislative amendments to the *Mental Health Act 1990*, released in August 2006, was finalised as the *Mental Health Bill 2007* and tabled in Parliament in December, 2006.

The new Bill enhances the commitment to the protection of the legal rights of persons with a mental illness contained in the previous *Mental Health Act 1990*. Reactions to many changes in the Bill were positive (particularly supporting the recognition of the role of carers in sharing information, and consumer confidentiality). However, there was widespread discontent about issues that had been ignored in the face of widespread support.

A negative aspect of the Bill is that in the two Discussion Papers, the key focus of the Objects of the Act was to incorporate the spirit and intent of Parliament to set overarching parameters, thus giving guidance and assistance as to how more detailed provisions of the Act should be interpreted, so that good practice is entrenched in the legislation. MHCC recommended that the Act should be expanded to

include core '*Principles*', supporting a concept of overarching guidance to provide for the care, treatment and protection of people with a mental illness, informed by *UN Resolution 46/119, Principle 1: Fundamental freedoms and basic rights*.

Whilst the Objects of the Act also refers to the civil rights of those under the Act, there is broad consensus that the Act should recognise the needs of particular groups of people, for example: Indigenous, culturally and linguistically diverse groups, people with an intellectual disability, and recognition of the rights of carers who are under 18. MHCC would have liked to see greater acknowledgement included in the overarching *Principles of the Act*.

MHCC highlighted many issues previously raised in their submission *Response to the Mental Act 1990: Discussion Paper 2*. Some sections that were of particular concern were that:

- It is imperative that Mental Health Tribunals reflect a spectrum of clinical, legal and community expertise and not (as in some matters) be conducted by one person as drafted in the new Bill.
- MHCC felt greater clarity should be given to the definition of an accredited person and the qualifications necessary for nomination. This was identified in consultations as particularly important in rural, regional and remote locations where medical officers are frequently unavailable. The absence of an accredited person (a medical doctor or psychiatrist) frequently results in delays to both hospital admissions and release of patients back into the community.
- When dealing with limited further detention of a person taken to a facility by police or after Magistrate's bail, MHCC identified the ability to detain a person for no more than 1 hour (pending the person's apprehension by a police officer), as an inadequate time for the police to respond, which might put a person at risk.
- The Draft Bill included a section dealing with prohibited treatments, which included psychosurgery. Consultation revealed that some groups were happy to accept this amendment, however, in our submission, we stated our position which is in agreement with the conclusion of the Psychosurgery Review Working Group: Medical knowledge and technology are evolving fields and psychosurgery can be effective for, "a very small and specific group of patients suffering from some chronic, disabling and treatment resistant psychiatric illnesses." In stating this position, we also advocate for a proviso that rigorous safeguards must be implemented to ensure that any intervention is in the patient's best interests, that consumers are fully informed of their rights, options and possible consequences of the procedure, and that any consent is a genuinely informed consent. The new Bill however, reflects the prohibition as drafted.

## Recognition of the rights of patients, the role of carers, and their right to obtain information

The Bill overhauls provisions of the current Act to update and streamline practices and services. Some of the amendments particularly affect the role of carers and consumer rights. This recognition is present throughout the Bill. In particular, Chapter 4 clearly sets out the rights of consumers and carers, which include:

- Principles for care and treatment based on the principle of the least restrictive environment enabling effective care and treatment
- Provisions allowing the nomination of a primary carer
- An amendment that enables carers to obtain an Interim Court Order, to obtain confidential information and urgent assessment when an individual is at risk is now reflected throughout the Act, which MHCC welcomes.
- Enhanced information sharing provisions including notification

requirements about medication, detention, conduct of inquiries and appeal rights

- An obligation on the part of the authorised medical officer of a mental health facility to consult with patients, carers and other relevant agencies in relation to discharge planning and follow-up care

The Bill also provides clarity and balance around the training of professionals in all contexts to understand their obligations, to seek information from and disclose to carers, the implications for all other community based organisations, and the rights of consumers and carers under the various Mental Health and Privacy Acts.

For any further information with regard to this submission please direct enquiries to Corinne Henderson at [corinne@mhcc.org.au](mailto:corinne@mhcc.org.au) or telephone 02 9555 8388 ext 101. The full submission is available on the website at [www.mhcc.org.au](http://www.mhcc.org.au)

**The Consultation Paper on the Forensic Provisions of the Mental Health Act 1990 and the Mental Health Crimes Act 1990** is under review at present. MHCC is facilitating a consultation for this review

# MHCC Consultation 2007

JOINTLY FACILITATED BY MHCC & NCOSS

Members and Interested Stakeholders are invited to participate in a consultation.

## **Review of the forensic provisions of the Mental Health Act 1990 & the Mental Health Criminal Procedure Act 1990.**

A copy of the consultation paper can be accessed at  
[http://www.health.nsw.gov.au/pubs/2006/mh\\_forensic.html](http://www.health.nsw.gov.au/pubs/2006/mh_forensic.html)  
We welcome any comments or written contributions.

DATE: THURSDAY, 8 MARCH 2007 • TIME: 9.00AM – 12.30PM

VENUE: BALMAIN TOWN HALL (Ground Floor Meeting Room)  
370 Darling St, Balmain, opposite Fire Station.

Register via email to Corinne Henderson at [corinne@mhcc.org.au](mailto:corinne@mhcc.org.au) or telephone: **02 9555 8388 EXT 101**

### PRESENTER

Professor Duncan Chappell, lawyer and criminologist is currently Professor in the University Sydney Law Faculty, and Acting Director of the Faculty's Institute of Criminology. He was President of the Mental Health Tribunal until early 2006, and is a member of the NSW Law Reform Commission.

### PRESENTER

Linda Steele, solicitor for the Intellectual Disability Rights Centre, is also a member of the Australian and New Zealand Association of Psychiatry, Psychology and Law and the Coalition on Intellectual Disability and the Criminal Justice System.

# Mental Health is about

This is a section from the upcoming MHCC publication *Mental Health is about*

**It is now well known that an important part of having and maintaining good mental health lies in feeling included within society. For people living with a mental illness, social inclusion plays a central role in recovery.**

In relation to this, the literature tells us four main things:

1. recovery from mental illness does occur;
2. social inclusion aids recovery;
3. social exclusion impedes recovery; and
4. attitudes of other people strongly influence how well people recover.

Following is an outline of some key evidence relating to these four things in turn.

## 1. Recovery occurs

The 1990s has been labelled the “decade of recovery”, as it was during this period that the concept of recovery gained credibility, largely through the emergence of consistent evidence that showed people can recover from mental illness, and, following the initial onset of mental illness, further episodes can be prevented.

Prior to this, it was generally thought that recovery did not routinely occur, and this informed how mental health systems were set up and run. It was thought that the condition of people diagnosed with mental illness would, at best, remain constant, and at worst, deteriorate, and mental health systems were therefore designed to maintain people in a state of illness rather than focusing on how to enable and support recovery. In this context, it is clear to see the thinking behind the concept of asylum and indefinite detention.

We now know that most people do recover or significantly improve following a diagnosis of mental illness, if they are provided with quality care and support. This evidence has come from consumer accounts and a series of outcomes studies.

### As Mead and Copeland (2000) state:

Now the times have changed. Those of us who have experienced these symptoms are sharing information and learning from each other that these symptoms do not have to mean that we must give up our dreams and our goals, and that they don't have to go on forever. We have learned that we are in charge of our own lives and can go forward and do whatever it is we want to do. People who have experienced even the most severe psychiatric symptoms are doctors of all kinds, lawyers, teachers, accountants, advocates, social workers. We are successfully establishing and maintaining intimate relationships. We are good parents. We have warm relationships with our partners, parents, siblings, friends and colleagues. We are climbing mountains, planting gardens, painting pictures, writing books, making quilts, and creating positive change in the world.

Consumer accounts, particularly in the USA, have provided compelling personal stories of a broad range of “the many and varied individual pathways of recovery”. Unzicker, for example, has told her recovery story, a journey from 10 years of “pills, shrinks, labels, powerlessness and hopelessness” to a position of wellness, engaged and active in society. Dr Daniel Fisher, a psychiatrist with a history of hospitalisation for schizophrenia, became a strong advocate for recovery and

consumer empowerment, and openly discusses his recovery in presentations and publications.

In the late 1980s and early 1990s, Harding and colleagues were among the first to conduct outcomes studies showing people diagnosed with severe mental illness were recovering. Their Vermont longitudinal study of long term outcomes of people diagnosed with schizophrenia in the 1950s showed that more than 60% of the sample of 118 consumers had fully or largely recovered. In a subsequent paper that compared the findings of five long-term outcomes studies, Harding et al found that the papers consistently showed between half and two thirds of patients recovered.

Alongside this came improvements in medications, and an increased focus on human rights, lending further support to the idea that long term institutionalisation is unacceptable and, in most cases, unnecessary.

## 2. Social inclusion is good for mental health and recovery from mental illness

Social relationships and social support are important for good mental health for all people, and for those recovering from mental illness, re-connection with society promotes recovery and decreases the chance of relapse.

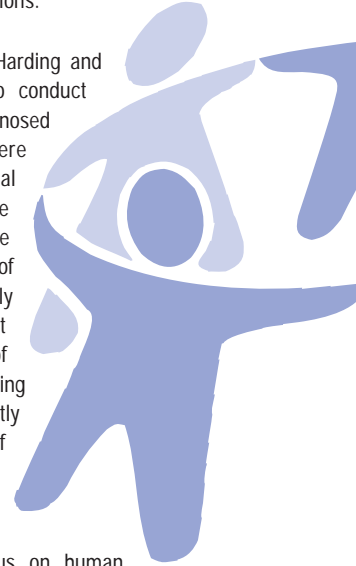
Social connections include engaging with friends and peers, maintaining employment and economic wellbeing, undertaking education, art, hobbies, and other activities, physical exercise, leisure and recreation, and social relationships. Engagement in society encapsulates the principles of having a sense of purpose and agency, feeling safe and secure, being free from violence or the threat of violence, and having hope for the future.

There is little prospect of accessing work or community activities by people whose housing is unstable, who have problems with money, who are unable to access affordable transport, and who feel isolated by stigma and the fear of discrimination.

People with serious mental illness are more likely to have smaller social networks (average size is 5 to 13 people) than the general population (25 people), and their network tends to decrease in size as the duration of illness increases.

A number of studies have confirmed the link between social inclusion and recovery from mental illness. Pevalin and Goldberg, for example, in a large-scale UK study of over 15,000 people, demonstrated that low social support increased chances of onset and decreased chances of recovery.

In a recent New Zealand survey with people who had recovered from mental illness, help from others was by far the most frequently mentioned theme, and all 40 participants identified assistance from



# out Social Inclusion

ocial Inclusion. The full referenced version will be available shortly from MHCC.



other people as important to their successful recovery. Family and mental health workers were the most common source of help, and each was mentioned by over half. More than half also referred to help received from groups, including support groups and therapy groups. Another study found that friends were rated by consumers as the most important contributing factor to staying well

Part of the recovery framework includes working on the broader impact that mental health problems can have on an individual's life. This includes the impact of losing a job, interrupted schooling, and losing contact with friends and family. It also includes the increased sense of isolation that other people's attitudes to mental illness can bring.

Serious mental illness can also have a devastating impact on functioning which contributes to the ongoing level of disability. Functioning includes the activities of daily living such as preparing food, maintaining hygiene, taking care of one's living space, having a routine – in other words, those basic skills required for community living.

While it is clear a reduction in symptoms is necessary for recovery, it has been increasingly recognised that many people need help to build or re-build their ability to function well, as improved functioning does not automatically follow a decrease in symptoms. This can require the support of a number of different kinds of support agencies. Consumers and carers value improved functioning very highly, and one study found that they value this more highly than improvement in symptoms.

The central role of engagement and functioning in society to recovery from mental illness can make the recovery process quite complex, and we need to be working with each individual to identify what their needs are, including both medical and social. This calls for a multi-layered approach, well beyond what is possible within the biomedical model alone. The Sainsbury Centre for Mental Health offers a useful framework, identifying three different ways of thinking about inclusion and how this might be applied for each person's recovery process: a) as access to information and decision-making; b) as standard of living, including health, opportunities to learn skills, earn a wage, and live in safety; and c) as relationships with others replacing dependence on the mental health system.

### 3. Social exclusion impedes recovery

The experience of mental illness can be profoundly isolating, and this is only made worse when combined with the additional experiences of social stigma and isolation.

People diagnosed with a mental illness can enter a vicious cycle of

social isolation. The diagnosis can be alienating, which can make the consequences of the diagnosis worse, which can lead to greater isolation, and so on. Stigma and social rejection are strongly linked to this vicious cycle, and one outcome of this cycling is limited access to health treatment and to justice, presenting almost impenetrable barriers to recovery.

Consumers commonly report difficulties with making and sustaining relationships, maintaining formal and informal networks, and managing tasks of daily living. These difficulties can exacerbate feelings of low self-esteem and lack of agency, which spirals into serious exclusion and isolation. Their lives can become "dominated by a fight to overcome personal and social problems and access appropriate support".

In the context of mental health care, when people are isolated from the general community during their recovery, they can become trapped in a system that "reinforces social stigma, reduces access to normative feedback and resources, encourages passive adjustment, and solidifies social withdrawal"

In other words, isolation during illness and recovery adds to the burden of the illness, and directly impedes the healing process.

### 4. Other people's attitudes are crucial

The consequences of mental illness, including discrimination and stigma, can be just as debilitating (or more so) than the illness itself. Further, they add to the longevity of disablement and disadvantage.

In the Waikato University Mental Health Narratives Project, just as the support of others was the most commonly identified factor in facilitating recovery, it was the attitudes and behaviour of other people which were far and away the most common hindrance to recovery. What got in the way of recovery were other people's fears, their

stigmatising behaviour, their lack of understanding, and their rejecting behaviour in relation to mental ill health.

Stigma and discrimination work directly against recovery, as they directly lead to and reinforce social exclusion at both an individual and systemic level. In one study, the researchers found that more than one third of employers believed people with a psychiatric disability to be violent or stupid. Frost and colleagues conclude that employers' reluctance to hire people known to have a mental illness is likely to be due to a lack of understanding, while Graffam and colleagues cite several studies showing that previous positive work-related experiences make employers more positive towards hiring people with disabilities. In other words, once the mythology based on myth and stereotype is broken down by exposure to someone with mental illness, attitudes do change. From changed attitudes comes inclusion, which leads to further changed attitudes, and so on.

Combating negative stereotypes and attitudes remains one of the most crucial aspects of promoting mental health for all people. Better engagement and social inclusion of people living with mental illness will both help this process and be helped by it.

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# MHCC response to the Guardianship Amendments

The NSW Guardianship Tribunal has been operating since 1989 providing a vital service to protect and promote the rights of people with disabilities. The Guardianship Tribunal is a legal tribunal established under the *Guardianship Act 1987* (NSW). The Tribunal's primary function is to appoint substitute decision makers for adults with decision making disabilities.

One of the principal responsibilities of the Guardianship Tribunal is to ensure fair administration of the *Guardianship Act 1987* (NSW). This includes reviewing ways in which legislation can be improved to better protect and promote the rights of people with decision making disabilities.

In view of the fact that alteration to the Act has far-reaching and serious consequences on people with disability, impacting on their autonomy to make decisions affecting all aspects of their life, MHCC emphasised concern that insufficient exposure had been given to the review process. Without involving all interested stakeholders, the process fails to advance the Tribunal's integrity.

By an large, MHCC regard the proposed amendments as unambiguous in their intent to cut costs, despite comments to the contrary, and unlikely to foster the quality of the Tribunal to deliver services to people with disabilities that protect and promote their interests. We expressed the opinion that services should not be compromised and must accommodate both growth and a changing demographic profile of the population.

The following issues were of particular concern:

- **Composition of the Guardianship Tribunal** – it has been proposed that the Tribunal be reduced to fewer than 3 persons to hear reviews of guardianship and financial management orders and applications for major medical or

dental treatment. MHCC are of the opinion that the legislation as it stands acknowledges the importance of a broad spectrum of legal, clinical and community expertise in making decisions that seriously impact on a person's autonomy and therefore do not support such an amendment to the legislation.

A decision is much more likely to be considered legitimate if made by three people, and this would to a large extent contain the necessity for appeals contesting determinations (through the Supreme Court or Administrative Decisions), which MHCC feel would pose a barrier to most people with a disability.

- **Increased flexibility to make non-reviewable Guardianship Orders** – MHCC rejected this amendment. Whilst review of an order of specified or short duration may be unnecessary and may be allowed to lapse, a Principle of the Act is that, "the freedom of decision and freedom of action of such persons be restricted as little as possible." A decision must be reviewable so as to ensure the preservation of an individual's rights.

- **The Role of the Registrar to be extended to exercising procedural functions** – Whilst MHCC support the Registrar exercising some additional functions that were listed we strongly object to the Registrar exercising functions that require the expertise and criteria on which Tribunal members are appointed. We strongly advocate individuals have a right to have their requests considered by those most qualified to do so.

For further information on this submission, please contact Corinne Henderson at [corinne@mhcc.org.au](mailto:corinne@mhcc.org.au) or telephone 02 9555 8388 3xt 101. A copy of the full submission is available on the MHCC website [www.mhcc.org.au](http://www.mhcc.org.au)

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## Unanimous Support for Disability Agreement

The Senate Community Affairs Committee tabled its unanimous report into the funding and operations of the Commonwealth State Territory Disability Agreement in early February 2007. The Senate Inquiry heard evidence from consumers, their carers and the disability service sector. Data received by the bipartisan committee highlighted a huge needs shortfall in service delivery throughout Australia. The report details examples of inadequacies in the funding system that left a man bedridden because he didn't have access to an electronic wheelchair. In another instance the parliamentary committee heard that a 35 year old intellectually disabled man has been on a waiting list for seven years for supported accommodation.

Committee member and former health minister, Kay Paterson, indicated the committee was 'nothing short of embarrassed...at the lack of services and the fragmentation of those services' at the launch of the report on 8 February.

The report calls for real changes to be implemented by Commonwealth and State governments if the CSTDA is to deliver real benefits to people with disabilities.

### Key recommendations of the report included:

- More funds to be allocated if the CSTDA is to meet the real needs of people with disabilities.
- Develop Avenue national disability strategy
- Improve the availability of equipment such as wheelchairs
- Key areas in need of attention: whole of life planning; specialised assessment teams; indexation; portability and advocacy
- Greater consideration of individual control of funds where appropriate.

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# Welfare to Work forum a success

Almost 50 people attended MHCC's information forum on Welfare to Work on 13 February, where Melissa Coad from the Welfare Rights Centre presented the most recent information on the legislation. The feedback overall was very positive, with many suggesting MHCC should continue to run these events regularly to help people stay up to date, and have the main aspects of the legislation explained in Plain English.

## Some things about Welfare to Work you may not know...

The following aspects of the Welfare to Work legislation have recently been brought to our attention thanks to one of our members. We welcome input from all members if you come across something you think others should know about. Contact Rachel at MHCC with your ideas. Did you know about the following ... ?

### Newstart 'Partial Capacity to Work'

The Newstart Partial Capacity to Work benefit is available for consumers who are ready to work, but for fewer than 30 hours per week. The obligations are less than what is required of other Newstart recipients, and the person can access some of the benefits of the disability pension.

People receiving Newstart who are assessed in their Job Capacity Assessment as having a "partial capacity to work" (which means they can work between 15 and 30 hours per week) will have reduced activity requirements compared with those on the full Newstart.

To have a partial capacity to work a person must:

- have a psychiatric, physical or intellectual impairment that prevents 30 or more hours work per week, and
- because of that impairment not be able to undertake a training activity that would enable 30 or more hours work in the next two years.

People with a partial capacity to work will only have part time participation requirements and will only have to look for part time work of between 15 to 25 hours per week. If a person is already working 15 hours per week there will not be any additional activity requirements.

People with a partial capacity to work may also receive (where eligible), the Pensioner Concession Card, Pharmaceutical Allowance, Telephone Allowance, a higher rate of Mobility Allowance and a higher rate of Employment Entry Payment.

### Vulnerability Flag

Centrelink has a system whereby a person assessed as being vulnerable will have a "flag" placed on their record. The intention is that this information allows Centrelink and Employment Service Providers to be aware of circumstances which may affect a person's ability to comply with their activity requirements. The presence of the vulnerability indicator on a person's record will not necessarily mean that they will not have participation failures recorded. It only means that staff will exercise more caution in imposing them.

Currently Department of Employment and Workplace Relations policy requires that medical evidence is provided in order for Centrelink to record vulnerabilities where the person has a medical condition. Other "categories" of vulnerability, such as homelessness do not require medical information and can be recorded by Centrelink staff.

### Disability Pension Assessments

This matter has caused a lot of confusion among the community. Currently a person receiving the disability pension (DSP) is not required to look for work. However if s/he wishes to look for work and voluntarily registers with an Employment Service Provider, s/he will have to undertake a Job Capacity Assessment. This Assessment may result in the decision that they are capable of work and therefore no longer eligible for the DSP.

MHCC believes this can be a disincentive to people to voluntarily look for work. It is hoped the government will look at changing this so that a person who voluntarily registers with an Employment Service Provider does not risk losing their DSP eligibility to do so.

Anyone who was receiving DSP prior to 10 May 2005 will be assessed under the old rules (which means they may be able to retain the DSP if they are assessed as being unable to work more than 30 hours per week). But anyone who started receiving DSP after 10 May 2005 will be subject to the new rules. This means if they are assessed as being able to work more than 15 hours per week, they may be placed on a different benefit such as Newstart or the Youth Allowance that requires them to undertake activities such as looking for work.

MHCC believes this can be a disincentive to people to voluntarily look for work. It is hoped the government will look at changing this so that a person who voluntarily registers with an Employment Service Provider does not risk losing their DSP eligibility to do so.

*Our thanks to Melissa Coad from the Welfare Rights Centre, Sydney, for providing this information in response to our questions.*

# Where to from here?

## AN UPDATE ON MHCOPES

Many of you may remember MH-CoPES from the Stage 1 Project, and may be wondering what is happening with it now.

Just a refresher: the Mental Health Consumer Perceptions and Experiences of Services (MH-CoPES) project is being conducted by NSW Consumer Advisory Group - Mental Health Inc (NSW CAG) in conjunction with the NSW Department of Health. It aims to develop a process for consumers to put forward their feedback which will help guide service improvement.



*The Honourable Cherie Burton, the Honourable Carmel Tebbutt and Dr Gillian Malins at the launch of the MH-CoPES Stage 1 Report.*

The MH-CoPES Stage 1 Report was officially launched on Thursday 23rd November, 2006 by the Honourable Cherie Burton, Minister Assisting the Minister for Health (Mental Health). During her speech, she thanked the Technical Working Group for their work throughout Stage 1. She also spoke about the importance of improving Mental Health Services for consumers and the role that MH-CoPES will play in providing consumers with an opportunity to participate in service evaluation and improvement.

The Stage 1 Report, available at [www.nswcag.org.au](http://www.nswcag.org.au), outlines the achievements of MH-CoPES Stage 1: the development of a draft Framework for Consumer Evaluation of Mental Health Services and the draft MH-CoPES Questionnaires. The Report provides 10 primary recommendations to NSW Health for developing opportunities for consumer evaluation of mental health services in NSW.

MH-CoPES Stage 2 is now underway. This project, which runs until the end of 2008, will look at many of the recommendations from Stage 1 and will further develop the MH-CoPES Framework and Questionnaires ready for implementation across adult public Mental Health Services in NSW. To achieve these objectives, NSW CAG will be conducting a trial of the Framework and Questionnaires in North Ryde and Orange. While this is happening, InforMH, NSW Health will be introducing MH-CoPES across the state.

If you have any questions regarding MH-CoPES, please contact Karen Oakley, Project Officer, NSW CAG or Rebecca Doyle, Research Assistant, NSW CAG on 02 9332 0243 or [koakley@nswcag.org.au](mailto:koakley@nswcag.org.au).

Look out for MH-CoPES; it will be coming to you soon.

## New opportunities for Mental Health Nurses

New employment opportunities will soon be available for mental health nurses with the upcoming launch of the COAG New Funding for Mental Health Nurses Initiative.

The new positions will provide coordinated clinical care for people with severe mental disorders in the community under new funding arrangements to be implemented in July 2007. General practices, private psychiatrist services and other appropriate organisations (eg. Aboriginal Medical Services) can receive funding to engage mental health nurses to provide a range of assessment and management interventions needed by mental health clients, their families and carers.

The initiative acknowledges the need to support private psychiatrists and GPs who care for around 200,000 people with a severe mental illness. Having a trained nurse available to arrange services for patients and provide ongoing clinical care will help to ensure that the patients get the right services at the right time, and may also prevent unnecessary hospital admissions.

Government estimates propose that by 2011, through this initiative, more than 36,000 patients will receive specialist mental health nurse support each year.

Mental health nurses will need to be credentialled by the College of Mental Health Nurses to be eligible to apply. Being a credentialled mental health nurse is not the same as being a member of the College, and the College cites the following benefits of obtaining a credential: professional and personal satisfaction; recognition as a mental health nurse, respect from employers and other health team colleagues; increased confidence; client trust and improved career opportunities.

Further information is available from the College at [www.anzcmhn.org](http://www.anzcmhn.org) or by phone on 1300 667 079.

### NEWS IN BRIEF

#### Interchange Respite Care Research Project – call for participation

Interchange respite care are gathering research on unmet needs and their impact on respite care. Respite care would like assistance in distributing information about the project and inviting consumers to participate in a survey. The survey form is available on the website and can be filled in electronically. For more information contact Respite Care at [admin@interchange.com.au](mailto:admin@interchange.com.au) Or visit the website at: [www.interchange.com.au](http://www.interchange.com.au).

# Drought Relief

**A \$1million drought assistance package has been announced by the NSW Government to address mental health problems in drought-affected communities throughout the state.**

The Centre for Rural and Remote Mental Health (CRRMH) is overseeing the roll-out of the package, and MHCC is one of the many organisations involved in the steering committee.

The package will fund:

- 6 mental health workers;
- 15 farmers' mental health workshops;
- 50 mental health first aid (MHFA) training sessions for service providers; and
- A mental health resource package for health and agriculture support workers.

93.2% of NSW is now officially in drought, and a further 4.7% is marginal. The aims of the initiative are to increase early identification of mental health problems and appropriate referral, community education, interagency collaboration, and building sustainable changes.

Locations of the MH workers and MHFA training have not yet been determined, but this will occur shortly. It is envisaged that since there are only 6 MH workers, they will have an outreach and coordination role to develop sustainable partnerships.

The farmers' mental health workshops are in addition to the large

number of farmers' family gatherings currently happening across NSW, and will have a clear mental health focus. The proposed locations are: Broken Hill, Condobolin, Corowa, Cowra, Crookwell, Deniliquin, Enngonia, Gunnedah, Inverell, Inverell, Mudgee, Singleton, Temora, Trangie/Warren, Walgett, and Wentworth.

## Rural Mental Health Support Line ph: 1800 201 123

A 24 hour 7 day a week mental health support line has been put in place by NSW Health for farmers and other members of rural communities.

Many people in rural communities are facing pressures they find difficult to cope with, and need to speak to someone about their problems. The hotline can be accessed by people wanting to talk directly to someone, or by friends or family members who are concerned about someone else.

The Rural Support Line can provide on-the-spot help in an immediate crisis, or help with referral to local specialist services.

## DPI Drought Donation Register

The NSW Department of Primary Industries (DPI) has established a drought donations register designed to co-ordinate donation delivery to families in the bush struggling with the drought.

DPI will register donation pledges, and welfare organisations will access the register and arrange to receive and deliver the donation directly to those most in need. Groups and individuals can register their donation by contacting the hotline 1800 814 647.

# MISA Pilot Project

**The MISA (Mental Illness Substance Abuse) Pilot Project is a partnership project matching mental health non-government organisations (NGOs) with drug and alcohol NGOs. The aim is to build the agencies' capacity to respond to clients with mental illness and substance abuse (MISA) issues.**

The Pilot Project is a joint initiative of the Mental Health Coordinating Council (MHCC) and the Network of Alcohol and Drug Agencies (NADA). The partner organisations provide overall management and resources for the project by providing a part time Project Officer, workshops for the participating agencies and a small grant allocation to support the strategies and initiatives of the partner NGOs. An independent evaluator has developed an evaluation framework and a final report on the outcomes of the Pilot Project will be prepared on its completion in June 2007.

## Youth

The partner agencies are Richmond Fellowship, South Sydney Dual Diagnosis Service and Ted Noffs Foundation. The main initiative of the partnership is a Forum for the staff of the participating agencies. The Forum will provide an opportunity for each of the partners to present their service delivery models in depth. From these shared experiences, the organisations will formulate and document their knowledge on collaborative care models. The partnership will share data collection methods with the aim of assisting research in the area of young people and MISA issues. Networking and resources will be shared with the South Sydney Youth Dual Diagnosis

drama group who will perform at the Youth Dual Diagnosis Forum organised by Richmond Fellowship for Mental Health Week.

## Women

The partner agencies are Charmian Clift, Phoebe House and WHOS New Beginnings Women Services. The main initiative is the development of customised training for staff in the partner agencies. Training will focus on sharing expertise and experience between the agencies and includes a component on parenting issues for women with MISA issues. Other initiatives being explored are staff swaps and site visits.

## Adult residential

The partner agencies are Hunter region PRA and WHOS. This partnership was the last to join the Project. At this stage Initiatives being considered are site visits for staff, staff swaps, training and joint case management of some clients.

A key feature of the project to date has been the informal contact and communication that has developed between the partner agencies. Additionally, through regular Project workshops there has also been contact across the three larger partnerships groups. Although working with different target groups common themes and issues have emerged. Agencies

have had time to share their experience, recognise the expertise and have begun to identify potential ways of working together to share and pass on this expertise. An added bonus has been the opportunity to collectively problem-solve issues confronting work in this field.

There are three concurrent projects, each targeting a different client group.

While each of the partnerships is developing uniquely, they all have a common goal of increasing capacity to meet the needs of clients with mental illness and substance abuse issues.

# Where is Healthelink up to?

By Michelle Bonner, NCOSS

## Update

In NSW the electronic health record system, Healthelink project, is being piloted until September 2007 in two areas, Hunter/New England and Western Sydney. The Hunter/ New England pilot is focused on people aged 65 years and older with a chronic disease, whilst the Greater Western Sydney pilot is focused on child health by targeting children aged 15 years and under.

Health services involved in the pilot will include GP Practices, Community Health Centres and Hospital services such as emergency departments, discharge, inpatient and outpatients units, pathology and radiology.

Recent data provided by Healthelink shows that over 4000 people have enrolled in the electronic health record pilots across both sites. The overall opt-out rate of consumers (people deciding that they do not want their health record to be part of the electronic health record system) is approximately 5.7%, or 225 people. 81 people have registered to have access to their own health record.

## Consent

Accessible and user-friendly information on Healthelink is vital to ensure consumers are making informed decisions and understand both the risks as well as the benefits of participating in the pilot. Children and young people, people of culturally and linguistically diverse backgrounds, and people with a disability who simply may not receive or understand the written materials are especially vulnerable. NCOSS has raised a number of concerns about the standard information kits provided.

## Privacy

Some personal or health information may be filtered out prior to being lodged with Healthelink. Currently in the pilot, this information is limited to adult and child sexual assault, data from PANOC (Physical Abuse and Neglect of Children) services, all HIV associated test results and all molecular genetics and cytogenetics test results from the Hunter New England Area Health Service.

For all other personal health information, a consumer can choose which organisation or facility has access to their electronic health record. For example, a consumer can choose to only allow access to their electronic health record by the GP Practice or local hospital.

Consumers need to be aware however that health providers from other facilities will be able to access their health record in emergency situations - this type of access is known as 'break the glass', and the Privacy Policy states such action will require a reason to be recorded and will be auditable. However the definition of what is an emergency situation and what is considered an acceptable reason is not outlined in the policy.



The Privacy Policy also explains that a healthcare provider can request that access to a consumer's health record by the consumer be restricted. This refusal or restriction of access can only occur in limited circumstances and covers situations where access places any person at risk of harm, including where the consumer's physical and mental health may be affected or where others may be placed at risk.

## Pilot Evaluation

An evaluation framework for the Healthelink trials is still being developed. It is anticipated that the successful tender for the evaluation will be announced in January 2007. NSW Health has agreed that NCOSS can consult with consumers about the evaluation framework once a draft is completed.

## Other key issues

Currently people who are homeless are not included in the pilot. It is expected that the Healthelink evaluation will consider information needs of people who are homeless ie : How will they receive information kits, be informed of any trials or implementation of an electronic health record and have access to their own records?

There is a lack of clarity about the time period the electronic health record will be kept for? Current medical records are generally stored for 7 years. How will an electronic health record be stored and then disposed of?

A community consultation strategy will be developed mid year by Healthelink prior to any state wide implementation of an electronic health record.

For further information on the work NCOSS is undertaking through their role on the Healthelink Steering Committee visit the NCOSS website [www.ncoss.org.au](http://www.ncoss.org.au) and go to Hot Issues.

The NSW Healthelink website [www.healthelink.nsw.gov.au](http://www.healthelink.nsw.gov.au) provides current information on both pilot sites as well as an on line demonstration for practitioners. The website is yet to develop an on line demonstration model for consumers.

# ASCA

## (Advocates for Survivors of Child Abuse)

ASCA (Advocates for Survivors of Child Abuse) is the only national organisation to specifically meet the needs of adult survivors of childhood abuse. Since 1995 its door has been open to anyone (over 18) who has suffered any form of childhood abuse or neglect. ASCA has already helped tens of thousands of child abuse survivors. Many of these have now rejoined society – returning to work, their health improved, and with an enhanced sense of self-esteem and well-being. Hundreds of thousands more Australians need our help.

Australia is in the throes of 'a child abuse epidemic,' (AMA, NAPCAN, Ken Moroney, NSW police commissioner). Child abuse extracts a terrible price, not just on individuals as children, but throughout their adult lives. The cost for individuals is high and that cost for society is climbing steadily.

Child abuse is the root cause of many of Australia's social ills – substance abuse, welfare dependency, homelessness, crime, relationship and family breakdown, chronic physical and mental illness. People in these groups typically demonstrate an incidence of past childhood abuse of 60-80%. A history of childhood abuse of any sort, including neglect, is a factor in many psychiatric and physical health problems. [Note to designer ; highlighted paragraph following] Research clearly links child abuse with higher rates of depression, anxiety, substance abuse, suicide, eating disorders and post-traumatic stress disorders in adults. The mental health repercussions of abuse are substantial.

However the provision of services for survivors is extremely limited. The oft-quoted "one in three girls and one in six boys", applies to sexual abuse only, and is a gross underestimation, given the stigma and silence of victimhood. The vast majority of child abuse notifications do not relate to sexual abuse.

Advocates for Survivors of Child Abuse (ASCA) can and does make a substantial difference. Our support network – online, phone and face-to-face – provide ongoing support, and our professionally-facilitated programs and workshops and monthly newsletter inform, educate and facilitate recovery. Our website is comprehensive and state-of-the-art and offers an expanding interactive capacity. ASCA offers services which are affordable, accessible and specific to their primary needs. Survivors' issues are complex and impact many aspects of individuals' lives and community well-being.

Without ASCA, Australia's burgeoning numbers of survivors would have no effective means with which to address their complex needs. The impact of child abuse is all-encompassing and requires a multi-dimensional holistic approach. These issues cross departmental boundaries and if not effectively targeted, the life-long impact of child abuse continues to stretch already stretched government health and social services.

Child abuse and mental illness are both taboo subjects. When they occur together, as they so often do, they engender the deepest fears. ASCA is working to erode the stigma and silence that has stopped victims accessing the support they need. Whilst many survivors can be easily identified, far more remain hidden within our society. Some are not even aware that they are survivors until the cause of their distress is identified. In 2007 ASCA is planning a media campaign to raise awareness around abuse issues, specifically the legacy that survivors experience.

No child deserves to be abused or neglected; every adult who has been deserves to receive the help and support he/she needs. ASCA's vision for the future is to see a world without child abuse. Sadly this is but a dream, but we will continue to work towards it. In the meantime we will continue to help and support survivors overcome the impact of their abuse.

Kids First Foundation (2003) estimates child abuse and neglect costs Australian taxpayers almost \$5 billion a year, of which the long-term human and social cost is 2 billion per annum.



**ASCA**

**FOR MORE INFORMATION ON ASCA**  
(Advocates for Survivors of Child Sexual Abuse)

Please visit our website on [www.asca.org.au](http://www.asca.org.au),  
Phone 1300 657 380

or download our podcasts from  
<http://www.asca.org.au/news/podcasts.html>



## March 2007

NSW MENTAL HEALTH NGO CONFERENCE



### REGISTER NOW: LAST CHANCE!

'Count Me In' Innovative community based approaches to better mental health

**When:** 1 - 2 March, 2007

**Where:** Sydney Masonic Centre

For more info: Ph: 02 9555 8388 x0 or E: [info@mhcc.org.au](mailto:info@mhcc.org.au)

**Partnerships for Better Health Outcomes: Carers and professionals working together**

**When:** 8 - 9 March, 2007

**Where:** Dockside, Cockle Bay, Sydney

For more info: Ph: 02 9280 4744 or E:

[conference@carersnsw.asn.au](mailto:conference@carersnsw.asn.au)

or visit: [www.carersnsw.asn.au](http://www.carersnsw.asn.au)

**9th National Rural Health Conference**

**When:** 7 - 10 March 2007.

**Where:** Albury

For more info: [www.ruralhealth.org.au](http://www.ruralhealth.org.au) Ph: 02 6285 4660

or E: [conference@ruralhealth.org.au](mailto:conference@ruralhealth.org.au)

## April 2007

**The ACROD 2007 Ageing and Disability Conference**

**When:** 2 - 3 April 2007.

**Where:** Hilton Hotel, Adelaide

For more info: Ph 03 9362 0800 / 0411 773 707 E:

[philippa.angley@acrod.org.au](mailto:philippa.angley@acrod.org.au)

or visit: [www.acrod.org.au/conferences/a&d2007](http://www.acrod.org.au/conferences/a&d2007)

**Towards Better Practice: Enhancing collaboration between mental health services and women's domestic violence services**

**When:** 2 April, 2007

**Where:** Rozelle Hospital Conference Room

For more info: [c.kennaugh@edfac.usyd.edu.au](mailto:c.kennaugh@edfac.usyd.edu.au)

## May 2007

**13th Annual Hunter Mental Health Conference - Resilience - Key to Thrive**

**When:** 18 May 2007

**Where:** Noahs on the Beach, Newcastle NSW

For more info: [Kate.Simpson@hnehealth.nsw.gov.au](mailto:Kate.Simpson@hnehealth.nsw.gov.au)

Ph: 02 4954 6655 / 0407 907 396

**NSW HACC and Community Care Conference - Call for papers**

**When:** 14-15 May

**Where:** Sydney Convention and Exhibition Centre, Darling Harbour.

For more info: [annab@agedservices.asn.au](mailto:annab@agedservices.asn.au)

## MHCC STAFF AND CONTACT DETAILS

View from the Peak is published four times a year. Editorial material is welcome but there is no guarantee on publication or return of originals. Please forward your copy to the Editor, Stephanie Maraz.



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Coordinating Council  
*funded by NSW Health*

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