

View

from the Peak

CEO REPORT

Jenna Bateman

NGO Mental Health and D & A Research Grants

Look for this \$3 million grant program to commence in August – September 2007. Grants will be available for NGOs to partner with established research bodies such as universities, institutes and Area Health Services to explore innovative approaches to working with people who have mental health and drug and alcohol problems. The program has been funded by NSW health and will be jointly administered by MHCC and the Network of Alcohol and other Drug Agencies (NADA). Research proposals will be assessed in line with priority areas detailed in the NSW Mental Health and Illicit Substance Comorbidity Framework for Action (2007):

- Workforce planning and development
- Infrastructure and systems development
- Responsiveness in priority settings for priority clients
- Promotion prevention and early intervention strategies

The EOI process will be in two stages to allow organisations to submit initial research ideas detailing broad objectives and project scope. From these proposals a review panel will invite selected applicants to further develop their applicants for the tender selection panel.

As part of this initiative MHCC will provide support to mental health organisations wishing to consider undertaking research who may not have been active in this area before but who are keen to build some research expertise into their organisation. Types of assistance on offer include facilitation of linkages with appropriate research partners; assistance with development of research proposals such as working up research ideas; determining research scope and methodology and meeting ethics requirements. In addition MHCC and NADA will set up an information sharing network of successful grant applicants with an aim of building the research knowledge base within the sector.

NGO Mental Health Infrastructure Grant Program – Round 2

The Infrastructure Grants Program (IGP) is funded by NSW Health and administered by MHCC. The IGP commenced in late 2006 and is expected to extend to late 2008. It is a one-off fund of \$4 million for projects enabling NGOs to improve existing services and progress towards accreditation with quality standards.

In Round One, funded projects included upgrading premises and equipment, engaging temporary officers to prepare services for accreditation review, improving databases to collect and analyse service quality information, and conducting research into improving partnerships and service access issues.

In Round Two, priority for allocating funds will be given to projects that progress NGOs towards accreditation, prepare NGOs for the introduction of routine consumer outcome measurement and information management systems, and target gaps in the mental health sector. An information pack is now available on the MHCC website www.mhcc.org.au.



MHCC will administer the IGP and conduct several projects to promote sector-wide infrastructure improvement, including the following:

- Sector Mapping and Resource Development – MHCC will undertake a mapping project of the mental health NGO sector during August to December 2007. This will provide updated information on the sector and identify gaps for future planning.
- Information Management – MHCC will explore the optimal information management systems, eg. IT software, to assist services in analysing service delivery and outcomes, with the

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Say Aaaah!

NEW DENTAL MEDICARE PROVISIONS

A new arrangement for dental Medicare provision, starting in November 2007, will improve access to Medicare funded dentist services. Changes to the way dental care is supported by Medicare is welcomed, as there has been very poor uptake of the scheme in its present form.

Under the current arrangement, general practitioners can refer patients to private dentists for treatment funded through Medicare. However the patient must present with 'a chronic non-dental disease to which their oral condition may be contributing.' Diseases include diabetes, mental illness, heart disease and a management plan must be prepared which involves referral to private dental services.

Another problem with the current situation is that only \$240 is allocated per person per year.

The new deal will increase individual treatment funding to approximately \$2100 each year and the Association for the Promotion

of Oral Health (APOH) is hopeful a widening of the definitions of chronic disease will make the scheme more accessible for those in need.



Federal Health Minister, Mr Abbott, at a recent Oral Health Advocacy Day at Parliament House, indicated there was no reason why the mouth should not be considered part of the body. APOH welcomed the comments and hopes that more medical practitioners will make use of the wider interpretation to make better use of the scheme.

WORKPLACE RELATIONS GETS A MINOR FACE-LIFT

Changes to the Workplace Relations Act were passed in Parliament on 21 June. The Workplace Relations Amendment (A Stronger Safety Net) Bill 2007 included a fairness test for workplace agreements and an obligation for employers to provide employees with a new Workplace Relations Factsheet.

There has also been the creation of new agencies: the Workplace Authority and the Workplace Ombudsman.

The Fairness Test

The Fairness Test has been designed to guarantee that protected award conditions, such as penalty rates and public holiday pay, are not traded off without fair compensation.

The Workplace Relations Fact Sheet

Under Workchoices, employers will now be required to provide all employees with a 'fact sheet' outlining employee rights and obligations. Employees who begin employment after July 20 must be provided with the fact sheet within 7 days. Existing employees must be provided the fact sheet before October 20 2007. The fact sheet is available at <http://www.workplaceauthority.gov.au/docs/EMPLOYERS/FactSheet/FS-WR-020707.pdf>.

Workplace Authority and Workplace Ombudsman

The new bill creates two new statutory agencies. The Workplace Authority will replace the Office of the Employment Advocate and the Workplace Ombudsman will replace the Office of Workplace Services.

FOR FURTHER INFORMATION CONTACT THE WORKPLACE INFOLINE ON 1300 363 264

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view to producing sector-wide data that is 'owned' and managed by the sector.

- Routine consumer outcome measurement (RCOM) – This project will deliver training to all interested NGOs throughout NSW during 2008. It fits with the development of the training package (funded under the NGO Development Strategy) and equipping NGOs with the necessary data analysis systems to measure their consumer outcomes.

AGM 2007

The MHCC AGM day has been set for Friday 30 November. All members will be invited to attend what is usually an informative and stimulating day. More details will be forthcoming shortly, but please put the date in your diary now.

Social Inclusion platform document.

You should have received a copy of the MHCC document Social Inclusion: Its importance to mental health. This document is important in that it contextualises the broad-ranging work we do in the NGO mental health sector. Our sector has not had this kind of document before, and whilst being a platform document in its own right, it also outlines many of the principles and practices that will inform the development of the Mental Health NGO Framework for NSW.

Executive Officer on leave

I am on leave for three months, and during my absence Rachel Merton will be acting in my position.

Best wishes,

Jenna Bateman, Executive Officer

MHCC Hosts CEO Forum

MHCC hosted a CEO forum on July 20 for the purpose of networking and information sharing. Several presentations on topics relevant to the sector were followed by an open forum where issues from the floor were raised.

WORKCHOICES

Paul Maguire and Mark Sullivan made a presentation about the issues and complexity around the definition of a constitutional corporation. There is still a lack of clarity around what constitutes trading, and what is the allowable proportion of an entity's activity that is defined as trading before that entity is deemed to be a constitutional corporation – and therefore required to comply with the Work Choices legislation.

The presenters' advice was to act as if you are a constitutional corporation unless you are certain you are not. On a practical level, this could mean entering into an Agreement with staff to override any Awards that may otherwise be applicable to them. As long as the conditions are equal to or better than the WorkChoices minimum standards, this will be acceptable under WorkChoices. It should be acceptable to staff if the conditions are at least equal to those under any existing Awards.

You will need to comply with any changes or requirements under WorkChoices, including the Fair Pay Commission's salary increases, and the one-page WorkChoices fact sheet that must be distributed to all staff by 20 October 2007.

INFORMATION STRATEGY

Jonine Penrose-Wall presented an outline of the information strategy that has the potential to have a "momentous" impact in our sector. We can share tangible information as a sector, in addition to sharing values as we currently do. Collective information that is owned by the sector will enable us to know and understand what we do, and to build a sector knowledge base.

Sector consensus meetings will be held during August to gather input into the process.

WORKFORCE DEVELOPMENT AND LDU

Heidi Freeman and Tina Smith presented draft posters and brochures from the workforce recruitment campaign that is currently underway. All invited parties were invited to make comments on the progress of the campaign and comment on strategy. Further comments and suggestions are welcome.

NATIONAL SENATE INQUIRY INTO MENTAL HEALTH SERVICES

Corinne Henderson facilitated a session seeking input from those present into MHCC's submission to this Inquiry. A large number of very valuable suggestions will be made. Corinne will compile all comments into the submission, and all members are welcome to contact Corinne to have further input.

OPEN FORUM

MHCC Chair, Leone Crayden, facilitated the open forum where the following issues were raised.



Some of the participants at the CEO forum

COMPETITIVE TENDERING

An ongoing and fraught issue! There is great value in working together and forming consortia where possible. Some recent tender processes have disallowed or discouraged consortia, which seems to work against good practice. Small organisations continue to have difficulty competing against large ones and consortia are a particularly good strategy for smaller organisations. 'Poaching' of other agencies' staff has been widespread in other sectors, and it would be a shame to see it in ours. It would be better for us to think as a sector rather than as a group of individual organisations.

WORKFORCE

It was acknowledged there is a lack of staff in every discipline, and this trend will continue for some time. We need to be smart with the resources we have. Peer supervision is one example of working with limited workforce. We need sector-wide career path options.

SACS AWARD

A number of members felt that the SACS Award doesn't apply well to our sector, and its conditions are below those of other Awards. It was expressed that the sector needs to factor realistic admin costs into tenders and have this acknowledged by funders. It was expressed that there is a need to change the assumption by NSW Health that basing staffing costs on the SACS Award is still the appropriate way to fund NGOs. As a sector, it was felt, that this issue should be taken up with the Government funding bodies.

WORKCHOICES

Following the presentation this morning, can MHCC draft a model sector template or guide for an Agreement with staff? The Aged Care Association has done this, and we could use theirs as a guide? MHCC to consider this.

GOVERNMENT FUNDING VERSUS OUR ADVOCACY ROLE

NGOs can find themselves in an awkward position criticising Government policy when funded by Government. Advocacy is such an important role for NGOs, and we need to have community support to keep doing this. Consumer voices are vital, and both individual and systemic advocacy can "save lives". Funds used for specific advocacy efforts that may be seen as challenging Government should be funded from non-Government funds.

Participants at the forum expressed strong support for regular forums. Keep an eye out for the next one and come along.

Training Just Got Easier

An online searchable training database is now available on MHCC's website. The database lists training, seminars and conferences relevant to workers and volunteers in community based mental health.

The database builds upon work previously undertaken by MHCC in the development of a biannual wall calendar of training opportunities for the sector. The wall calendar will continue to be produced,



showcasing a selection of courses most relevant for community based mental health workers across NSW. If you do not already have a copy of our July – December 2007 wall calendar, contact MHCC and we will send you a copy.

MHCC's new online searchable training database can be accessed from the homepage of MHCC's website. The database lists all the training, seminars and conferences that MHCC has been able to locate that are relevant to workers and volunteers in the non-government mental health sector. It will continue to be updated at

least monthly. While we've tried to find as many training courses and programs relevant to the community based mental health sector, there may be training opportunities that we might not know about that could be of interest to our members. If you are aware of any appropriate training possibilities that could be included on the database, please let us know.

People wishing to access information can search the database under the following search fields:

- Course title
- Course topic
- Course provider
- Cost
- Region
- Accreditation status
- Keyword

The database was developed by Michael Chan, a volunteer sourced through Goodcompany – a non profit organisation connecting skilled professionals with charitable organisations in need of pro bono assistance. (www.goodcompany.com.au)

MHCC is very grateful for the work that Michael has done for us. The database he has developed will greatly assist community based mental health care workers and volunteers to find relevant training, seminars and conferences. This inturn will help to ensure the sector is well informed and educated about relevant industry developments and practices.

Thank you very much to both Michael Chan and Goodcompany!

If you have any questions or comments about the training database, or have courses, seminars or conferences you would like to list on the database, then please contact Nicole Schlederer or Heidi Freeman at MHCC, on Ph: 02 9555 8388 x107, email: nicole@mhcc.org.au.

Double Suicide: Tragedy Exploited

In May the 60 Minutes Current Affairs show aired a program on the tragic double suicide of two teenage girls. The program included detailed information regarding the method of suicide, footage of the exact location and interviews with family and friends that has sparked reactions from numerous organisations working in the community mental health sector.

Organisations including the Hunter Institute of Mental Health, SANE Australia and the Mental Health council of Australia, believe the program gave unnecessarily detailed information regarding the method of suicide used and gave undue attention, to the point of romanticising, the location of the tragedy. Jealea Skehan of the Mindframe National Media Initiative at the Hunter Institute wrote to the Nine Network to express concerns raised by the style of coverage and possible breaches to the Free TV Code of Practice.

Section 4.3.9 of the Free TV Code of Practice states that (In broadcasting news and current affairs programs) 'Licensees should broadcast reports of suicide or attempted suicide only where there is

an identifiable public interest reason to do so, and should exclude any detailed description of the method used. The report must be straightforward and must not include graphic details or images, or glamourise suicide in any way.'

International research shows that explicit description of suicide and suicide attempts may increase 'copycat' suicide attempts. The unnecessary romanticising of a suicide pact may place vulnerable viewers of such programs at risk and undo the good work of many organisations that work to improve the way mental health and associated issues are reported in the media.

The concerned organisations, unsatisfied with the response from the 60 minutes program, believe the story breached a number of the Codes by revealing too much detailed information regarding the suicides and the methods used to interview bereaved relatives and the provision of warnings related to the program content. The matter has been referred to the Australian Communications and Media Authority, which deals with breaches to the Free TV Code of Practice.

YARNING ABOUT MENTAL HEALTH

Aboriginal Mental Health Work Practice

Approaches to Aboriginal mental health issues - while of the utmost importance in their own right - seem to greatly mirror the concerns of all Australians who want to receive individualized and culturally competent mental health care that promotes both recovery and social inclusion.

On 11 July, a one day forum, "Yarning about Mental Health", was convened by MHCC, in partnership with Parramatta Mission, for community-based mental health service providers in NSW. The presentation was delivered by representatives from the Menzies School of Health Research who have been conducting an Australian Integrated Mental Health Initiative (AIMHI) project in the Northern Territory that aims to improve the mental health outcomes of rural Indigenous people.

The day was facilitated by three Indigenous mental health workers and a non-Indigenous psychiatrist, Dr Tricia Nagel, who has been working with Aboriginal populations for more than 20 years. The similarities and differences in the needs and wants of both the "top end" and other Indigenous groups – both rural and urban - were explored throughout the day in what became an increasingly valuable and informative exchange.

A feature of the day was the sharing of the pictorial "Mental Health Stay Strong Care Plan Package". This is a brief motivational interviewing approach to care planning with Indigenous Australians – from initial problem assessment through to goal setting and review – that is structured, sensitive and flexible to the needs of both people affected by mental health problems and mental health service providers.

Many aspects of Indigenous mental health care were explored on the day and these included:

- Consideration of both current and historical cultural issues in mental health service delivery.
- Aspects of Aboriginal life and culture that can help people with mental health problems "stay strong"
- The importance of care that targets communities and wellness;
- A greater reliance on verbal and visual approaches to care planning and review; and,
- Numerous statistics related to indigenous mental health.

More information about this approach including purchase of care planning resources can be obtained from www.menzies.edu.au or Ph 08 8922 8196

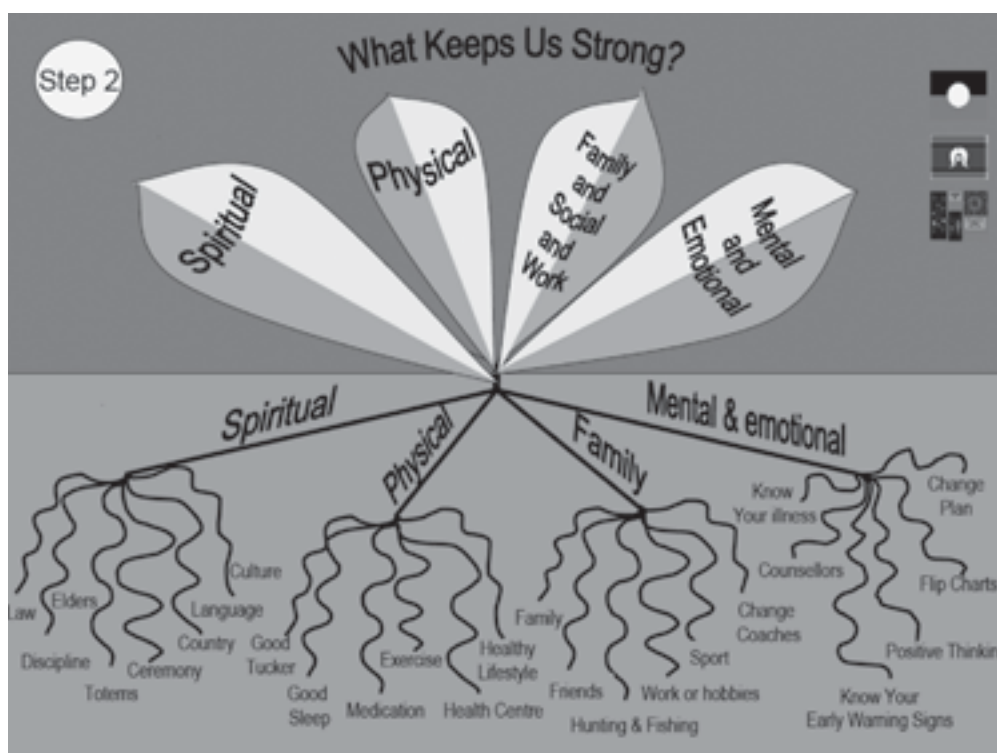
The MHCC has been listening to community organisations working for mental health who want to better address the needs of Indigenous Australians with mental health problems. Some have suggested value in convening future forums that bring together Indigenous mental health workers only to strengthen culturally competent approaches. We believe that much work is ahead of us all in this important area and would be interested to hear more from you about how to prioritise approaches?

QUESTIONS TO ASK

- What keeps us strong?
- What makes us sick?
- What are we like when we are sick?
- What gets us well again?

WHAT TO DO

- Talk to someone
- Do more of what is working (to help keep you strong)
- Do less of what's not working
- Then, if the problem is still not solved, seek professional help and treatment



Show me

Suffering acronym fatigue? Find some of the new initiatives available of the newer grant programs re

COMMONWEALTH INITIATIVES

The following Commonwealth initiatives have come out of the COAG National Action Plan on Mental Health 2006-2011, which aims to:

- Reduce the prevalence and severity of mental illness in Australia
- Reduce the prevalence of risk factors that contribute to the onset of mental illness and prevent longer-term recovery
- Increase the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention
- Increase the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation

Department of Health and Ageing (DOHA)

More information on these grants is available at www.health.gov.au

DAY TO DAY LIVING

The Support for Day to Day Living in the Community (D2DL) program aims to improve the quality of life for individuals with severe and persistent mental illness by providing an additional 7,000 places in structured and socially based activity programs. The initiative recognises that meaningful activity and social connectedness are important factors that can contribute to people's recovery.

HOW MUCH: \$46 million over 5 years

SUICIDE PREVENTION PROGRAM

Funds to expand and enhance current suicide prevention efforts. Funding will be provided under the National Suicide Prevention Strategy for national and community based projects.

HOW MUCH: \$62.4 million over 5 years

TELEPHONE COUNSELLING SELF-HELP AND SUPPORT PROGRAMS

Funds to increase telephone and web-based counseling services and self help resources targeting individuals common mental illness.

HOW MUCH: \$56.9 million over 5 years

DRUG AND ALCOHOL AND MENTAL ILLNESS

Improved services for people with drug and alcohol problems who also experience mental illness.

HOW MUCH: \$73.9 million over 5 years

MENTAL HEALTH SERVICES IN REMOTE AND RURAL AREAS

Funds to improve mental health services for people in remote and rural areas.

HOW MUCH: \$51.7 million over 5 years

MENTAL HEALTH NURSES

New funding to assist people with severe mental illness to receive better coordinated treatment and care. Funding will be provided for mental health nurses in private psychiatry practice, general practice and other appropriate organisations including Indigenous health services.

HOW MUCH: \$191.6 million over 5 years

BETTER ACCESS TO SPECIALIST TREATMENT

Funds to improve early detection, treatment and management of mental illness in the community through improved access to psychiatrists, psychologists and GPs and encouraging health professionals to work together.

HOW MUCH: \$538 million over 5 years

EARLY INTERVENTION SERVICES FOR PARENTS AND CHILDREN

Funds to assist parents and schools to better identify children at risk of mental illness and to offer early referral for appropriate treatment.

HOW MUCH: \$28.1 million over 5 years

MENTAL HEALTH IN TERTIARY CURRICULA

Funds to increase the mental health content in tertiary curricula.

HOW MUCH: \$5.6 million over 5 years

ALERTING THE COMMUNITY TO LINKS BETWEEN ILLICIT DRUGS AND MENTAL ILLNESS

Funds to help people better understand the links between drug use and development of mental illness.

HOW MUCH: \$21.6 million over 5 years

IMPROVING THE CAPACITY OF HEALTH WORKERS IN INDIGENOUS COMMUNITIES

Funds to improve the capacity of the Indigenous mental health workforce.

HOW MUCH: \$20.8 million over 5 years

the money

finding it hard to get your head around it? Here's a brief look at some relevant to our sector.

Department of Family and Community Services and Indigenous Affairs (FACSIA)

More information on these grants is available at www.facsia.gov.au

PERSONAL HELPERS AND MENTORS PROGRAM

In April, the government announced the successful service applicants for the Personal Helpers and Mentors demonstration sites to provide intensive support for people over the age of 16 with a severe functional limitation due to mental illness. These teams will assist people to access a range of services and supports, and to manage their daily affairs. With an emphasis on social connection as an essential element of recovery, 28 NGO services successfully received funds to implement these programs (see Autumn edition of VFP).

HOW MUCH: Total funding of almost \$284.4 million over the next 5 years.

MENTAL HEALTH COMMUNITY BASED PROGRAMS

This program aims to provide support to families, carers, children and young people (16-24) affected by mental illness through a diverse range of community programs. The program will seek to build on family strengths improve resilience and family functioning, especially for Indigenous families and those from culturally and linguistically diverse backgrounds.

HOW MUCH: \$45.2 million over the next five years.

MENTAL HEALTH RESPITE PROGRAM

Part 1 – A brokerage service in all Home and Community Care (HACC) regions using the existing network of Commonwealth Respite and Carelink Centres to increase choice and flexibility for carers, consumers and their families.

Part 2 – Using the National Respite Development fund (NRDF) to supply services where they are needed.

HOW MUCH: \$224.7 million over 5 years

Department of Education, Science and Training (DEST)

More information on these grants is available at www.dest.gov.au

HELPING YOUNG PEOPLE STAY IN EDUCATION

Funds to assist approximately 6000 young people a year who experience mental illness who are at risk of dropping out of school.

HOW MUCH: \$59.5 million over 5 years

ADDITIONAL EDUCATION PLACES, SCHOLARSHIPS & CLINICAL TRAINING IN MENTAL HEALTH

Funds to increase the supply and quality of the mental health workforce.

HOW MUCH: \$103.5 million over 5 years

Department of Employment and Workplace Relations (DEWR)

More information on these grants is available at www.dewr.gov.au

HELPING PEOPLE WITH A MENTAL ILLNESS REMAIN IN EMPLOYMENT

Funds to provide 2,500 additional places in the Personal Support Program (PSP) to help people with a mental illness who are not yet ready to benefit from the Job Network. The funds will also provide more support for people with a mental illness who are at risk of losing or leaving their jobs due to their condition.

HOW MUCH: \$39.8 million over 5 years

STATE RUN PROGRAMS

The following NSW funded programs are part of the Specialist Outreach Support Program, which in turn are part of the Mental Health Community Rehabilitation Program.

CARE COORDINATION PROGRAM

A new State initiative, not a grant program but a strategy, the Care Coordinating Program, aims to bring together clinical and community services for people with a mental illness. Under the program, people within the target group will be offered a clinical provider and a community coordinator.

The clinical provider (a GP, mental health nurse, hospital doctor, or where appropriate an Aboriginal health worker) will be responsible for the clinical management of the person.

The community coordinator will be responsible for coordinating the person's non-clinical, community based needs such as accommodation, employment, education and psychosocial rehabilitation.

RECOVERY AND RESOURCE SERVICES PROGRAM (RRSP)

The aim of this funding program is to strengthen the partnerships between stakeholders and service providers to maximise the effectiveness of support for people with a mental illness. NGOs support for people with a mental illness needs to demonstrate strong links with consumers and other agencies and not duplicate other services.

HOUSING AND ACCOMMODATION SUPPORT INITIATIVE (HASI)

The Housing and Accommodation Support Initiative (HASI) is a partnership program funded by the NSW government that ensures stable housing linked to specialist support for people living with mental illness. The program is a partnership between NSW Health, Department of Housing and the NGO sector.

The program has a recovery focus and provides permanent housing and long term flexible support that takes into account varying levels of recurring episodes or ongoing levels of psychiatric symptoms and disability in individuals.

Disability Funding in Crisis

In an alarming development, Federal Minister Mal Brough has withdrawn an offer of matched funding to all states that allocates new funds as part of the Commonwealth State Territory Disability Agreement (CSTDA). The surprise announcement on July 4 will affect all states except WA, NT and ACT, and will mean that growth funding in the area of accommodation and respite care for people with disabilities will be greatly affected. NSW could lose up to \$428 million in matched funding over the next 5 years.

Negotiations between states, territories and the Commonwealth have been underway to negotiate a new CSTDA to replace the previous agreement that expired on June 30 2007. The Commonwealth had announced an 'open cheque book' offer to match dollar for dollar any extra funding allocated by states and territories in an attempt to address the unmet demand for supported accommodation and respite care. State and federal ministers were to meet on July 25 to further negotiate the terms of the new CSTDA. The uncapped Commonwealth offer was subsequently withdrawn without notice.

In late June the prime minister made an announcement that the Commonwealth Disability Assistance package, worth 1.8 billion, was in addition to the CSTDA offer of matched funding. The NSW 'Stronger together' funds in addition to the new Commonwealth Disability Assistance package could have provided an estimated 1500 new accommodation places across the state. However the Australian Institute of Health and Welfare believes 7 000-10 000 places are needed in NSW alone to address the accommodation crisis. A recent Senate Inquiry into the CSTDA recommended further spending on respite and accommodation support to help fill the gap between supply and demand for such services within the disability sector.

A position statement organised by NCOSS has been endorsed by a number of relevant organisations, including MHCC, outlining the community sector's response to the withdrawal of promised funds.

The paper calls for immediate action by the Australian Government to:

- Restore the CSTDA matched funding offer
- Maintain and strengthen the CSTDA as a national agreement
- Implement a transparent and equitable process for funds allocation for NSW and among states and territories
- Increase the indexation rate to at least 3.3%

The paper calls on the NSW Government to:

- Maintain and strengthen the CSTDA as a national agreement
- Hold firm with the states and territories in maintaining a multi-lateral approach to CSTDA negotiations
- Prepare a robust case for the Stronger Together expenditure and other plans for disability unmet need to attract CSTDA matched growth funding
- Ensure a balance, with all new funding, between crisis responses and planned alternate pathways that enable people with disabilities to move out of the family home prior to family breakdown

WHAT YOU CAN DO

- Write to your state and federal Members of Parliament and Senators with your concerns
- Write to your local papers
- Distribute this information to people with disabilities, their friends and families and through your networks



HELPFUL RESOURCES

Contact details for federal politicians can be obtained at: www.aph.gov.au

Contact details for state members of parliament are available at: www.parliament.nsw.gov.au

Senate Inquiry Report can be obtained at: www.aph.gov.au/Senate/committee/clac_ctte/cstda/report/index.htm

For copies of the position paper go to: www.ncoss.org.au/hot/disability/cstda-final-17july07.pdf

Mental Health & Mental Disorder

In the community based Mental Health Sector there can sometimes be confusion around the correct terms to use. In a recent discussion on the use of the terms 'mental health' and 'mental disorder', General Manager of Sunflower Services at the Schizophrenia fellowship, Bill Gye, had a very interesting and enlightening explanation of the relationship between these two terms.

from pain, or at least feeling that one can manage one's pain, a sense of control in one's life is important, friends, meaningful activity, for some a sense of achievement, for some a sense of security, etc..

Mental Disorder is usually premised on the notion that some underlying factors that affect our mental abilities and emotional stability are not functioning as well as they might. Of course some may wish to say that really what we have is only a difference and that

in some situations those differences can become an asset – but I will leave that alone for the moment. Mental disorder as usually understood is the brain's equivalent of other physical disorders that affect other organs and systems of the body and which also may result in functional disability (e.g. type 1 diabetes, asthma, aortic stenosis, etc.). Given the complexity of the brain with 100 billion cells, it is probably the case that everyone suffers some degree of mental disorder – we're still waiting for the perfect brain.

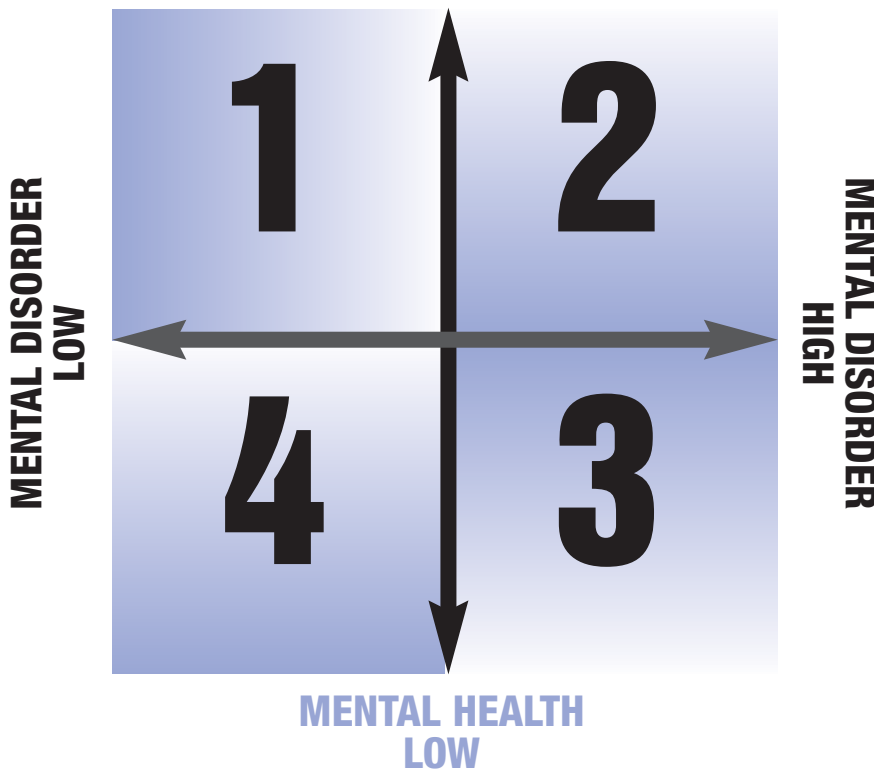
As the diagram indicates, the relationship between **Mental Health** and **Mental Disorder** allows for all sorts of interesting combinations. For example, it allows someone with a significant mental disorder to have a relatively high level of mental health (Quadrant 1). Ditto it also allows someone with a relatively low level of mental disorder to have a low level of mental health (Quadrant 4).

We have more control over our mental health than we do our mental disorder. And while both dimensions are somewhat independent they both probably influence each other, so that by maintaining a relatively high level of mental health we may somewhat

decrease the dysfunctional influence of our mental disorder. Indeed it may well be the case that the capacity for self-healing in relation to any mental disorder is better supported by maintaining a higher level of mental health.

This distinction somewhat confuses the labels we use for the industry we work in. Do I work in mental health? Do I assist people with mental illness? None of these really cover it. I guess I work with people with mental disorders to help them to improve their mental health which in turn may help them to better manage the effects of their mental disorders. That is I attempt to support and assist some people to spend less time in quadrant 3 and more time in quadrant 1.

MENTAL HEALTH
HIGH



A distinction may be said to have some validity if it is found to be useful in practice. As the diagram indicates, *mental health* may usefully be thought of as a separate dimension to *mental disorder*. In this way of thinking mental health may vary from person to person and within each person through time. On the other hand mental disorder may be thought of as a more stable condition that may vary but usually much more slowly.

Mental Health at its broadest level may be considered similar to the common sense notion of happiness. Its major markers are feeling OK and for me being able to think clearly and freely. Mental health is affected by many factors such as physical health and relative freedom

Welfare to Work consultatio

Fear, confusion, and disincentives to seek work have emerged as key themes from MHCC's consultations about the first 12 months of the Government's Welfare to Work laws.

MHCC has consulted with consumers, carers, and people working in the mental health and disability employment areas to compile a report outlining the experiences of people affected by this legislation since it came into effect on 1 July 2006. Many of the comments relate to the inadequacy of the laws to address the support needs of people with mental illness, especially the episodic nature of many mental illnesses and how this affects employment capacity.

The findings are being written up into a comprehensive report with recommendations for changes to the legislation.

A re-cap of the Welfare to Work changes:

People who apply for income support now need to complete a Job Capacity Assessment (JCA). If the assessment indicates they can work 15 or more hours per week, they cannot access the Disability Support Pension (DSP). Instead, they may receive an Allowance level payment such as Newstart, Youth Allowance, or Austudy. Previously the cut-off work capacity was 30 hours per week for the DSP.

Allowances are lower than the DSP, and recipients must undertake job search activities and/or other obligations such as Work for the Dole.

There is also a tough new compliance and penalty system, which applies a suspension of payment for 8 weeks for a "serious" breach of the rules - including refusing a job offer or leaving a job. Similarly, three less "serious" breaches will see payments cut off for 8 weeks. For those deemed especially vulnerable, there is the option of financial case management, which involves charities and other community based organisations providing financial counselling and arranging for essential bills to be paid.

Following is a summary of the main issues that have come so far from the MHCC consultations.

Understanding the changes

Most respondents reported being confused about the changes, with many saying that they had never received information that was clear, concise and relevant. Carers also commented they felt left out of the loop, and only some were aware they could request copies of all correspondence as a primary carer.

Need for more flexibility between DSP and Allowances

There was general support for any efforts to help people with mental illness into the workforce, but consumers expressed fear that by entering the workforce, they would not be able to secure the Pension again if they became unwell and could not work. Unlike most other disabilities, mental illness is episodic, and people can be well for several years and then have a breakdown and become unable to work. It is at this point they need early and timely support, including access to financial support. There was a strong perception among consumers and carers that the new system makes it more difficult to access this support when needed.

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Employment itself can exacerbate illness. One example presented was of Bill (not his real name), who secured part time employment, performed well, and was pressed by his employer to accept additional hours and responsibilities. For a time, all was going well, until the stress became too much, the employer would not reduce his hours, and Bill became acutely unwell very quickly. He was then forced out of the workforce completely for quite some time.

One recommendation is that Centrelink be flexible in allowing people with mental illness to move between the Pension and employment/Allowance arrangements in line with their episodes of illness.

ns — a wealth of feedback

The lack of flexibility and the fear that by working, consumers will lose the Pension forever, has actively discouraged many from seeking employment.

Dealing with Centrelink

Consumers reported mixed experiences of dealing with Centrelink, but the main concern expressed was that there was often no-one on staff who seemed to understand mental illness, particularly when a consumer expresses frustration at the system and loses their temper. In this case, Centrelink staff reportedly will not deal with the consumer. The suggestion made was that there be at least one trained staff member, such as a social worker, available to manage these situations, and help consumers navigate the often frustrating and confusing system. One consumer suggested that “having Centrelink people not trained is like opening a Centrelink office without a wheelchair ramp”.

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Job Capacity Assessments (JCA)

There was a lot of feedback about the JCA process, with the main concern being that many JCAs have no experience or expertise in assessing capacity due to mental illness. The general feeling was that consumers feel compelled to present themselves as positively as possible, and their capacity on any given day may vary considerably depending on whether they are well or unwell. Many consumers may have capacity to work in a flexible environment where hours can vary, but this cannot be captured by the JCA process unless the JCA has a good understanding of mental illness.

Employers need to be better informed

There is a strong need for employers to be better informed about mental illness, as there is still discrimination and misinformation in the workplace.

There are potentially great roles out there for consumers

Consumers identified some potential employment opportunities in educating and training government staff, employer groups, and/or the general community. Such positions would have the dual advantage of increasing employment and addressing people’s lack of knowledge of mental illness. One consumer said her “years of experience as a consumer” could be an asset to share with others.

Disclosure vs non-disclosure

Consumers are often faced with the difficult decision of how much to disclose about their illness to potential employers for fear of discrimination. This is made more complex by the need to disclose everything to a JCA as part of an accurate assessment. Some expressed fear that the information would be shared among other government departments, and potentially impact insurance and superannuation.

Emphasis is too much on getting people into work, not supporting them to stay there

There was cynicism expressed about the Welfare to Work legislation’s focus on gaining employment with very little ongoing support to maintain employment. Ongoing long-term support is needed by many consumers to manage the stresses of employment and their own episodes of illness. Disability-specific job network providers tend to be very good at offering ongoing support, but many respondents were concerned that people are being referred to generalist job network providers who do not have this knowledge or level of support.

All members will receive a copy of the report once it is finalised, and it will be available on the MHCC website shortly.

Throw Stigma in the Bin!

Stigma is an overused term in mental health circles. Let's throw it in the bin!

I am against the usual focus on stigma; I think the focus is out of date and tired. Instead, we ought to be calling stigma what it really is – **discrimination**.

It is time for the mental health community to challenge the over-emphasis on 'stigma' and re-orient the debate towards 'discrimination'. Let's face it, we don't have an Anti-Stigma Act in NSW, but we do have an Anti-Discrimination Act. Nor do we have a Disability Stigma Act at the Commonwealth level; rather, we have a Disability Discrimination Act.

It is my view that the focus on stigma fails to deal with the issues as being that of discrimination, much of which is unlawful. The 'stigma' focus represents a mismatch between legislation and community campaigns – we have anti-stigma campaigns, yet we don't have anti-stigma legislation. We do have anti-discrimination legislation, yet we don't have anti-discrimination community campaigns.

When confronted with stigma, community members react to 'political-correctness'. They don't make the connection that stigma, i.e., discrimination, is potentially unlawful. Nor do they see themselves as people who perpetuate discriminatory attitudes. Is this because the mental health community has taken far too much effort over stigma, and not enough to tackle 'discrimination' in the community?

In splitting the community education campaigns into a more diluted stigma focus, we weaken the stronger and more useful concept of discrimination, and spend time and effort addressing stigma, by far the less useful concept to tackle. Better to depart from this approach and stop diluting the debate, and thereby weakening awareness in the general community, of the extent and nature of discrimination.

Whilst we continue to perpetuate the 'mark of shame' idea that stigma portrays, we let go an opportunity to tackle discrimination. When we say 'this is stigmatising' we miss the opportunity to say instead: *'this is discriminatory, and is potentially unlawful'*.

Stigma and anti-stigma campaigns perpetuate the very stigma they claim to be tackling by keeping the concept of stigma alive in people's minds. They keep the concept of a mark of shame in the spotlight in national and local campaigns. What they don't do as well, and what they ought to do, is address discrimination and the potential for discriminatory attitudes to be considered as unlawful conduct.

They don't address direct discrimination; indirect discrimination; unlawful and lawful discrimination. For this reason they are 15 years out of date (1992 being the seminal year for psychiatric disability discrimination becoming unlawful in Australia).

The strength of addressing the issues as being about discrimination is that the emphasis shifts back onto the person *doing the*

discriminating, and away from the person who is carrying this 'mark of shame'.

I am not ashamed to live with ongoing mental health problems, I don't live with 'a mark of shame' and feel stigmatised. What I do feel however is that discrimination lurks in all sorts of places – and this conduct as such, isn't my problem; it is the problem of the person/s doing the discriminating.



When they, in a workplace, use language such as 'psycho' or 'looney-tunes' they are not stigmatising me, they are discriminating against me and other consumers/survivors: their actions are unlawful, under Commonwealth Disability Discrimination Law (1992).

If I wasn't educated about this, as a consumer I might spend my life feeling 'stigmatised' and never know there is legislation to combat this conduct in workplaces. If I didn't know better, I would go around thinking that I was carrying a 'mark of shame', and that somehow I would have to learn how to cope with the issue of uncomfortable depictions of people with mental illness as loonies, etc. The responsibility would therefore fall on **my** shoulders, to learn how to cope, rather than on the shoulders of those who choose to use this language.

Since 1992, people living with mental illness and psychiatric disability have had legal protection from many forms of discrimination, in the arenas of education, accommodation, employment, goods and services, etc.

It is time to 'get with the program' so to speak, and catch up with the broader disability movement: and move further away from perpetuating 'stigma' as a useful construct for addressing discrimination, and start to tackle **discriminatory attitudes** directly.

Discrimination is not a form of stigma: it is the other way around. Stigma is a form of discrimination.

Call stigma what it really is: discrimination. Put the responsibility for this conduct on the shoulders of the person or persons doing the

Find that Statistic — Fast!

Writing a funding submission? Compiling a community campaign? Doing a brochure or an article about mental illness?

MHCC can't do all the work for you, but we can help with our ready reference to useful mental health statistics. Anyone who has written an article or a submission before knows that getting the right statistic can be time-consuming. Information about mental health and mental illness comes from a range of government reports, documents, surveys, and so on, and new releases come out all the time.

Now available online, the reference includes over 100 commonly-used and useful statistics with hyperlinks to their primary sources. Here are some examples of what you will find:

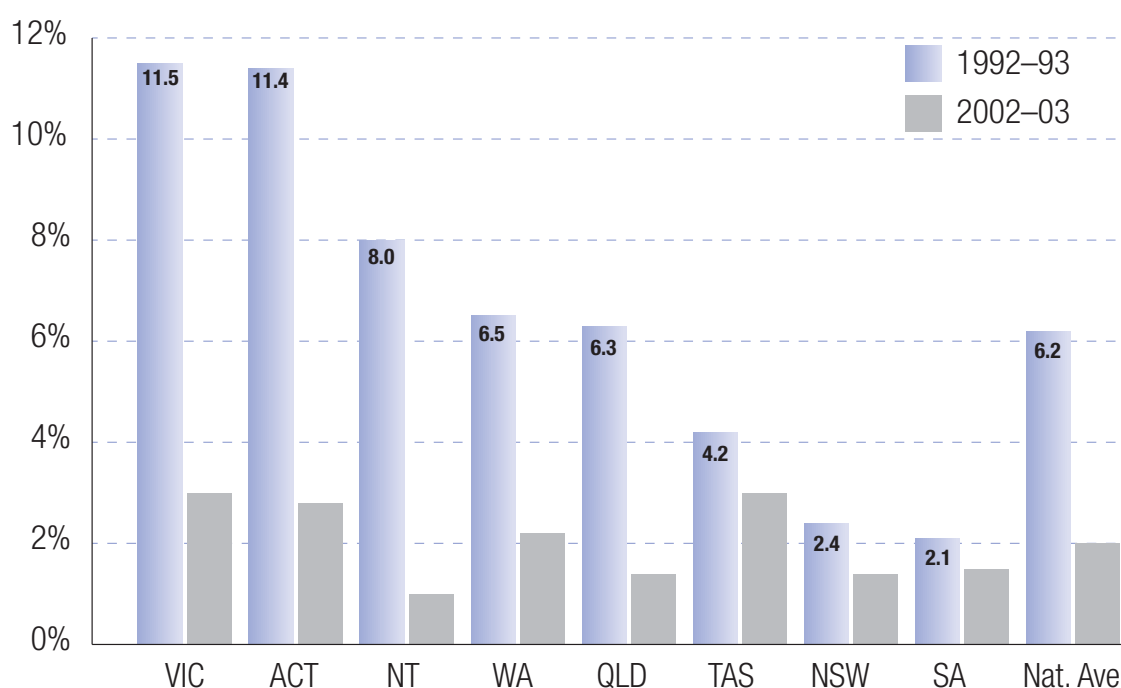
- 18% of adults have a mental health problem in any given 12 month period.
- Mental illness is the leading cause of non-fatal burden of disease in Australia (24% of total non fatal burden of disease).
- Suicide rates in NSW have been dropping over the last 10 years, and in 2005, 549 people died by suicide (a rate of 8.7 per 100,000 population) the lowest rate in 20 years.
- 80% of people who committed suicide in NSW in 2005 were

males, but 60% of those hospitalised for suicide attempts were females.

- There were approximately 48,223 mental health-related occasions of service in hospital Emergency Departments in NSW in 2004-05.
- The total public psychiatric beds in 2004-05 in NSW was 2056.
- In 2006, 11% of people discharged from mental health inpatient care were re-admitted within 28 days.
- In 2004, 21% of the total prisoner population was Indigenous. Indigenous people aged over 17 years were incarcerated at 11 times the rate of non-Indigenous Australians.
- In NSW in 2002-03, 2.4% of NSW mental health expenditure was on NGOs, well below the national average of 6.2%, and the second lowest of all states / territories.

Of course, this is a living document and will be updated constantly in response to updated statistics, as well as your suggestions for what else should be included. Contact Rachel Merton, Senior Policy Officer at MHCC with your suggestions and requests. The reference can be found at www.mhcc.org.au.

Funding to non-government organisations as a percent of total spending on mental health services



Source: Department of Health and Ageing, National Mental Health Report 2005, p. 5

MIEA to Pat the Dog

Judith Scott and Barbara Moffatt are retiring after a combined 30 years of service at the Mental Illness Education Australia (MIEA). MIEA began as a schools education project within ARAFMI and became an independent incorporated body in 1995. The aims of the organisation have been to raise awareness of mental illness in the community, particularly with young people; remove the stigma associated with mental illness; and to promote early intervention through schools presentations.

During its 12 years, the organisation has trained over 300 volunteers to visit over 200 schools, presenting to over 3500 students per year. Teams of two presenters, consisting of a consumer and carer, talk with students about mental illness from their own distinct perspectives. Judith says 'We just wanted to reach as many young people as possible. Early intervention is very important as a means of preventing long term illness.'

Both Barbara and Judith have seen many changes in the attitudes of young people since they began work in the area. Barbara recounts in the early days of the schools presentations that young people were not very forthcoming. 'In the past 5 years I have noticed a change in attitude. Young people are more open to discussing mental illness as it affects themselves and their families. I have heard young people talking about relatives having a mental illness in the same open manner that someone might talk about the flu. Even teachers have disclosed episodes of illness in their classes.' This breaking down of shame around mental illness is a positive step for sharing experiences and early intervention.

MIEA's achievements have not occurred in isolation and many organisations and individuals have been integral to the success of the

'I have heard young people talking about relatives having a mental illness in the same open manner that someone might talk about the flu.'

project. An important aspect of the organisation's development has been its links with the NSW Department of Education. By adapting the presentations to comply with the Department's syllabus, their work complements the school curriculum. Rather than perceived as an 'add on', MIEA's work dovetails into the PDHPE (Personal Development, Health and Physical Education) strand.

After 12 years as a small independent organisation, MIEA will merge with Black Dog. Seen as a necessary move to expand the community education programs of MIEA, Barbara is philosophical about the development. 'It's been a very challenging time for staff; to watch a program that you've nurtured from the very beginning grow into a professional, reputable organisation, be handed over to another organisation. However we are confident the program is going to people who will continue to grow and nurture it into the future.'

Even though Black Dog has had a focus on research and clinical approach to mood disorders (such as depression and bipolar) MIEA doesn't feel that their focus on a broader range of illness will be affected by the integration. Jude says

'In the present climate, a small NGO with a specific mission, such as ours, would not get the opportunity to grow and expand. We have put down strong foundations; they can build the house.'

Jan Pennington, the school program coordinator, remains confident that there will be little change to the program even after the re-location to Black Dog premises in the grounds of NSW University. If anyone is interested in a schools presentation, please contact Jan on (02) 9382 4530 or via email miea-nsw@unsw.edu.au

New Opportunities for Mental Health Nurses

A new and rewarding career option for mental health nurses wishing to work in the community is now available thanks to the Federal Government's Mental Health Nurse Incentive Program. The Program has been welcomed by the Australian College of Mental Health Nurses, who hail it as an opportunity for nurses to "fully utilise their highly developed clinical skills as well as co-ordinating clinical services".

The Australian Government is providing \$191.6 million over five years to enable community based general practices, private psychiatrist services and other appropriate organisations (such as Divisions of General Practice) to employ or contract mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders. These new arrangements commenced on 1 July 2007. In practice, this means that psychiatrists or GPs can employ a nurse to work from their clinic and/or conduct home visits to provide specialist care and coordination. MHCC would expect that the nurses

will liaise with all relevant services, including NGOs, to provide optimum coordination of care for each client.

According to the President of the College, Dr Stephen Elsom, this program enables community-based care for people who would not have been able to access it previously, and has the potential to prevent crises and deteriorating mental health through coordinated care in the person's home or in their GP's clinic.

From 31 December 2008, mental health nurses engaged under the initiative must be nationally credentialed by the College. In the meantime, there are interim arrangements in place to enable the initiative to start while nurses are becoming credentialed. The credentialing process will ensure that nurses have specialist qualifications, experience and a commitment to ongoing professional development. Further information about credentialing is available on the College website at www.acmhn.org.

Samaritans

Member Spotlight



Samaritans is one of the largest regional welfare organisations in Australia. Samaritans provides support to children, young people, those with a disability and families experiencing disadvantage in over 100 services or locations across the Hunter, Manning and Central Coast regions.

By the time clients come to one of our programmes, poor mental health is often already an issue for them – one that may or may not have been recognised or diagnosed. The presence of such issues exacerbates the reasons for which clients may be working with Samaritans – it's demonstrably more difficult to care for a family, or hold down a place at school or in a job when you're experiencing ill health.

Along with such disadvantages, clients often struggle with gaining access to service providers and mental health systems and this compounds their other challenges.

While Samaritans does not specialise in mental health services, the range and breadth of Samaritans and its clients provides the organisation with both an opportunity and an obligation.

Working in a community development setting and aiming to support clients through a strength based programmes, Samaritans has the

opportunity to identify, support and refer clients who would benefit from earlier access to appropriate mental health intervention.

Professionalism and the desire to ensure clients are capable of achieving their goals means it is incumbent upon the organisation to ensure that our staff and services are aware of, and connected to, the full gamut of health and welfare services.

A recent survey identified the magnitude and scope of mental health issues for our client base and highlighted the current level of staff qualifications in this area, providing pointers for future development. Samaritans is conducting "Rehabilitation for Recovery" training programmes to strengthen staff capabilities in understanding current trends in treatment methods.

Samaritans joined the Mental Health Coordinating Council to develop and enhance partnerships with mental health experts and services, understand the resources that are available for clients and better equip and train staff to work with clients.

We look forward to working with and learning from other MHCC members in order to achieve enhanced outcomes for our clients. For further information about Samaritans phone 02 4960 7100 or go to the website www.samaritans.org.au

AUGUST

MHCC MENTAL HEALTH FIRST AID COURSES - FREE

14-15 Aug: Denman

10 & 17 Aug: Collie

For more info: contact the Centre for Rural and Remote Mental Health on (02) 6360 7932

or email Sue.Knight@gwahs.health.nsw.gov.au

FARMERS' MENTAL HEALTH GATHERINGS

15 Aug: Wentworth

16 Aug: Broken Hill

24 Aug: Kyogle

For more info: contact the Centre for Rural and Remote Mental Health on (02) 6360 7932

or email Sue.Knight@gwahs.health.nsw.gov.au

KEEPWELL (AUST) WORKSHOPS

HEARING VOICES – A SIMULATED TRAINING EXPERIENCE

When: Tuesday 28 August 2007

Where: Rozelle Hospital Conference Centre

WORKING WITH VOICES

When: Wednesday 29 August 2007

Where: Rozelle Hospital Conference Centre

PSYCHIATRIC FIRST AID IN PSYCHOSIS

When: Thursday 30 August 2007

Where: Rozelle Hospital Conference Centre

For more info: go to www.keeepwell.com.au

SEPTEMBER

FARMERS' MENTAL HEALTH GATHERINGS

7 Sep: Hillston

For more info: contact the Centre for Rural and Remote Mental Health on (02) 6360 7932

or email Sue.Knight@gwahs.health.nsw.gov.au

THE ARTS ACTIVATED CONFERENCE

Organised by Accessible Arts, the peak organisation for arts and disability in NSW, in partnership with the Spastic Centre. The conference will be a celebration for all those passionate about people with disabilities and their active participation in the arts.

When: 26-27 September

Where: Sydney Conservatorium of Music

For more info: www.thespasticcentre.com.au/artsactivated/

OCTOBER

EMILY'S 100TH BIRTHDAY

Emily Paterson founded Aftercare in 1907 to assist people with mental disorders live more independent lives after leaving psychiatric institutions. This work continues today.

On World Mental Health Day 10 October 2007, Aftercare will commemorate its foundation with a celebration in the place where Emily Paterson lived with her cousin Banjo Paterson, the famous poet.

When: World Mental Health Day 10 October

Where: Banjo Paterson Park, Gladesville

For more info: www.aftercare.com.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.



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funded by NSW Health

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