

## Government? Not for profit? For-profit?

**“It doesn’t matter who delivers the service as long as it’s being delivered...”**

MANY will have heard this statement made and probably not agreed with it instinctively but struggled to articulate why it seems such a misleading assertion – after all on the surface it seems a reasonable enough thing to say. If all sectors are funded to employ equivalent practitioners then why (notwithstanding responsibilities upholding the *Mental Health Act*) should it matter who delivers what services and programs? And yet it does.

The lenses through which people are perceived, and the drivers behind service design and approaches, are actually very different in the three different sectors and this impacts what they are best placed to deliver. Put simplistically and overtly: people in the public sector are patients with symptoms who require treatment; in the private sector they are clients that require a service and generate a profit and in the community sector they are individuals that need support to live a ‘contributing life’.

Medicare Locals (MLs), which were parachuted in to do much needed population planning, have now become a quasi-non-government ‘fourth’ sector, further complicating the picture as they edge into traditional community and public sector areas of specialisation.

The failure of government to properly recognise these distinctions has seriously increased role confusion and led to the poor role delineation that the NSW mental health system is experiencing.

In the current environment, understanding the optimal delivery platform for any particular service response would seem economically sensible and yet there appears to be reluctance by government to really come to grips with why they should direct program responsibility to any particular sector. Instead, we see the intention of government under the Grants Management Improvement Plan (GMIP) to actively support the opening up of tenders for traditional community sector areas of specialisation to private for-profit providers and to MLs in the hope that this approach will bring increased professionalization and economies of scale. Missing from this equation is the quality and value brought to the same “event of service” by community organisations. It’s hard to imagine a large for-profit provider offering substantial free extra services simply because it’s possible and would be the right thing to do.

Correspondingly, under the NDIS private and community sector providers will compete for ‘market share’. Impacts of this will be for community sector providers to take on



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more private sector approaches, i.e. it is accepted that private providers are not required to share with others because of the financial driver to own ‘their’ clients to collect payments; they have a heightened need for distinct brand recognition to attract clients; an increased need to protect their intellectual property from other providers and taking as much market share as possible is seen as ‘good business’. In an environment where interagency collaboration and finding the best service mix for the consumer, their family and carers, is seen as best practice, these private provider drivers seem somewhat at odds with optimal consumer outcomes.

The problem for government is that there is very little research that has been done that clearly helps decision making in this space. Studies which clearly elucidate the long term value of investing in community sector, private for-profit or public sector approaches against a performance framework have not been undertaken. Community sector interests are confident that concepts such as social capital, community participation, community development, innovation, collaboration, and

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responsiveness are all outcomes of the lens they use to design and deliver services but confidence is not enough.

Over the next two years the landscape of providers (community organisations, MLs, private for-profit, public sector) in the mental health space is likely to change. Government has indicated it wants to outsource an increasing range of services currently provided through the public sector; it has also indicated it wants to dramatically reduce the number of organisations delivering services; to open up tenders to all comers and to contract them to meet priorities determined by government – a top down rather than bottom up approach. In addition it has given the Local Health Districts much greater autonomy to create local level solutions.

Agree or disagree with the soundness of this current approach, a comprehensive performance framework must underpin this next phase of activity. With the work of the NSW Mental Health Commission Strategic Plan nearing completion it is timely to put serious thought into how (among other things) a performance framework can focus on the effectiveness of different sectors to deliver different parts of the service system. We need good data so that down the track informed decisions about which sector or combination of sectors is best placed to deliver services can usefully be made in future planning processes.

Best wishes

**Jenna Bateman**  
Chief Executive Officer

## Work Integrated Learning:

### A New MHCC Project Participation Opportunity

MHCC has been funded by the Sydney Interdisciplinary Training Network to deliver the Work Integrated Learning Project during 2014. Part of this project will involve the

delivery of 'Teaching on the Run' (TOTR) training and explore its applicability to community sector settings. Participants will have the opportunity to participate in a post-training process to explore, create and trial a framework for peer supervision/coaching/mentorship.

TOTR is a program that was developed by two doctors from the University of Western Australia. This program is well respected and has been delivered widely across Australia. TOTR aims to help participants increase their skills and confidence in

teaching and practice supervision in the work setting by:

- Planning for, and recognising opportunities for teaching
- Gaining skills and experience in providing effective feedback

- Gaining experience with teaching skills using the four step approach
- Developing strategies to support learners in difficulty
- Making teaching part of your core business
- Providing groups with effective teaching.

The program requires participants to attend two face-to-face training days which consist of six modules. The modules are:

1. Planning learning
2. Teaching
3. Teaching skills
4. Supporting learners
5. Assessment
6. Effective group teaching

The course is limited to two groups of 20 participants and available 1-2 April and 1-2 May 2014 in Sydney. Priority of access is given to staff of MHCC member organisations and an EOI must be submitted for selection purposes.

For more information please visit [www.mhcc.org.au/home/mhcc-events/search-events.aspx](http://www.mhcc.org.au/home/mhcc-events/search-events.aspx)



#### This project is funded by:



#### Project partners:



## Experiences from the NSW Hunter NDIS Launch Site

ACTIVITY IN the NSW Hunter NDIS launch site continues to accelerate. Excitingly, we are in the early stages of witnessing people assessed as eligible for an NDIA Tier 3 community support package being assisted to exit Morisset Hospital - a long term sub-acute psychiatric hospital.

Another highlight of this quarter has been the inaugural Hunter NDIS Mental Health 'Community of Practice' (COP) Forum held on 23 January. More than 70 people attended with most being from the community sector and there were also a large number of Hunter New England Mental Health (HNEMH) staff. People from outside of the launch site also attended. NDIA and HNEMH representatives were available to respond to participant concerns and/or to follow-up on issues arising. Meeting Minutes are on our website.

Launch site activities such as the above enable MHCC to effectively contribute to other NDIS forums. One example of this is a national forum convened by NDIA on 31 January to explore the inclusion of mental health in NDIS. This forum was to discuss issues with a consultant contracted by NDIA to develop a discussion paper to explore:

1. the eligibility of people with psychosocial disability; and
2. coordinated and integrated responses to NDIS as this relates to mental health.

An emerging concern from the launch site relates to Section 55-57 of the *NDIS Act* (2013). This allows organisations to share client information with NDIA without written consent of the



Josh Fear/MHCA, Suzanne Punshon/NDIA, Tina Smith/MHCC and Sage Telford, NSW Mental Health Commission at the Hunter NDIS and Mental Health COP Forum.

client if it appears they may be disadvantaged through not being assessed for NDIS eligibility. The potential ethical and collaborative practice impacts of this need to be further explored towards reaching a sector position on this matter. In the interim, MHCC Members might consider at a minimum seeking a client's verbal consent and documenting the reasons why written consent has not been obtained prior to handing over information to NDIA. Of course, written consent in advance of sharing people's private information is always preferred and consistent with notions of person-centered care, recovery oriented practice and supported decision making.

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### PSYCHOSOCIAL OR PSYCHIATRIC DISABILITY?

PSYCHOSOCIAL disability refers to the disability experienced by people with mental health conditions due to impairments and participation restrictions relating to the mental health conditions. The impairments and participation restrictions could include the loss of or limitation to physical, social, emotional, cognitive or sensory function, reduced ability to experience full physical health, and many more.

Psychosocial disability is distinct from psychiatric disability in that psychosocial disability refers to the social consequences related to mental illness, whereas psychiatric disability focuses on the medically defined illness, symptoms and impairments.

While not all persons with mental illness will experience psychosocial disability, those who do are much more likely to experience significant disadvantages, including unemployment, poor housing, poor health and homelessness. There are currently very few services that work specifically with people with psychosocial disability, however, consumers and carers have indicated that appropriate support can significantly reduce the impact of psychosocial disability on a person.

*Source: National Mental Health Consumer & Carer Forum (2011). Unravelling Psychosocial Disability: A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions. Canberra: NMHCCF*

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NDIA has begun to post cumulative quarterly reports on their website: [www.ndis.gov.au/document/754](http://www.ndis.gov.au/document/754). Some figures from their report on the first six months are:

- The average size of support packages varies substantially across disability groups. People with neurological conditions are receiving the highest average packages (\$55,237), followed by psychiatric disability (\$53,044), intellectual/learning disability (\$38,331), physical disability (\$35,151), and sensory/speech disability (\$15,903).
- Of people making an access request, 8.2% have been deemed ineligible. Of those who become participants, people with intellectual/learning disability form the largest group (67%), followed by neurological disability (20%), sensory/speech disability (7%), physical disability (4%), and psychiatric disability (2%).

MHCC are advised that the 2% figure is 57 people and that the majority of these are in the Hunter launch site. It is interesting that so much of the early learning about the NDIS and mental health is occurring in NSW and MHCC

greatly appreciates our partnership with the Mental Health Commission of NSW to maximise opportunities for people affected by mental illness. However, the realisation that only 57 people with psychosocial disability have entered the scheme is of concern given the national target of 57 thousand people at full roll-out (ie, we are currently 0.001% towards reaching this goal).

People with psychosocial disability living in the Hunter launch site LGA's of Newcastle, Lake Macquarie and Maitland who have no or inadequate community support services need to be informed about the NDIS and referred to NDIA to be assessed for eligibility. Alternatively, if you know of a person with persistent and severe mental illness in need of multiple services you can refer to the Partners in Recovery Organisation in the Hunter who are working closely with NDIA.

For more information about the NDIS and psychosocial disability please visit: [mhcc.org.au/policy-advocacy-reform/influence-and-reform/ndis-and-mental-healthpsychosocial-disability.aspx](http://mhcc.org.au/policy-advocacy-reform/influence-and-reform/ndis-and-mental-healthpsychosocial-disability.aspx)

## Recovery in the NSW *Mental Health Act* (2007)

THE MOMENTUM of the 'Recovery Movement' has led to adoption of recovery orientated principles across much of the mental health policy and planning literature in Australia. However, to date, recovery principles have not actually featured in mental health legislation. We are hopeful that NSW like several other Australian jurisdictions is moving towards incorporation of recovery principles into mental health legislation.

**It is timely for this current review of the NSW *Mental Health Act* to consider the potential benefits of embedding Recovery Principles into the law.**

In 2012/13 the National MH Safety Quality and Partnerships Standing Committee oversaw the development of the National Mental Health Recovery Framework, which brings together a range of recovery oriented approaches underpinned

by the international literature. This presents a national understanding and consistent approach to mental health practice and service delivery. The framework also emphasises the need for service cultures and practitioner practice to be trauma-informed. In 2013, MHCC's position paper *Trauma-Informed Care and Practice: towards a cultural shift in policy reform across mental health*

*and human services in Australia - A National Strategic Direction* outlined that the role of mental health legislation, supporting regulations and policies in addressing and preventing trauma and re-traumatisation, requires consideration.

Reforms must be viewed against the background of international human rights developments, including the United Nations Convention on the rights of persons with disability (2006) and the Optional Protocol. It is timely for this current review of the NSW *Mental Health Act* to consider the potential benefits of embedding Recovery Principles into the law, thereby underpinning existing policy and practice directives.

There has been lively discussion during the consultative processes as to how a recovery orientation can sit alongside fundamentally coercive practices, in the context of involuntary treatment, and how the legislation could promote 'dignity of risk' and support decision-making processes. The Mental Health Commission of NSW has played an important role in facilitating these ongoing discussions exploring whether or not involuntary care and treatment must necessarily preclude people from consenting and participating in treatment choices.

## Heads up! Introduction to the Trauma-Informed Care & Practice Organisational Toolkit (TICPOT)

FOR SOME months now, MHCC have been developing TICPOT – one element of a broader national initiative promoting the integration of trauma-informed care and practice (TICP) across service systems and programs in Australia. The development of TICPOT stems from one of the recommendations described in MHCC's position paper (2013): *Trauma-Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia – A National Strategic Direction*.<sup>1</sup>

The toolkit will provide guidance towards the organisational change processes necessary to embed TICP principles into every aspect of an organisation. It is targeted at a broad range of community managed organisations across mental health and human service systems and sectors. An introductory training program to TICPOT is anticipated to commence in April 2014. TICPOT will include guidelines and assessment tools as well as the information needed to assist organisations begin their journey or build on existing trauma-informed policies and practices.

As an organisational change process tool, TICPOT will support staff and services develop and sustain quality improvement so that they can continue to be responsive to the needs of service users impacted by experiences of trauma; as well as embed a sustainable trauma-informed organisational culture that appropriately supports staff.

MHCC will be engaging and training up consultants that organisations can then contract to work with and support them through an organisational change process (OCP). Closely collaborating with staff across an organisation they will conduct a review of current policy, train staff to understand trauma, TICP principles and practice and provide the relevant tools and frameworks to support an organisation throughout the process.

The initial audit assessment process will likely throw up identifiable priorities for quality improvement that can be addressed in bite-size chunks. A course or courses of action will be identified that prioritise specific areas for quality improvement, over-time. The idea is to support best-practice in a way that an organisation can comfortably accommodate.

This process of becoming trauma-informed will likely need to be tailored to each organisation. It will be an evolutionary journey, with a universal aim to establish a cultural shift that will eventually become second nature, whilst remaining receptive to change and innovation in order to promote sustainability.

To express your interest in the TICPOT organisational change process, please contact Chris Keyes, Project Liaison and Development Team Leader at: [chriskeyes@mhcc.org.au](mailto:chriskeyes@mhcc.org.au)

1. [http://www.mhcc.org.au/media/32045/ticp\\_awg\\_position\\_paper\\_\\_v\\_44\\_final\\_\\_07\\_11\\_13.pdf](http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final__07_11_13.pdf)

### CONGRATULATIONS SUE SACKER!

MHCC would like to congratulate Sue Sacker, MHCC Treasurer and Deputy CEO of Schizophrenia Fellowship of NSW, on receiving the Medal of the Order of Australia (OAM) earlier this year.

Sue has worked tirelessly for more than 20 years to raise the profile of mental health and the great work done by community managed mental health services.

Sue was awarded the OAM for services to people with a mental illness, to local government, and to the community of Manly.



## CMHDARN – three years of capacity building!



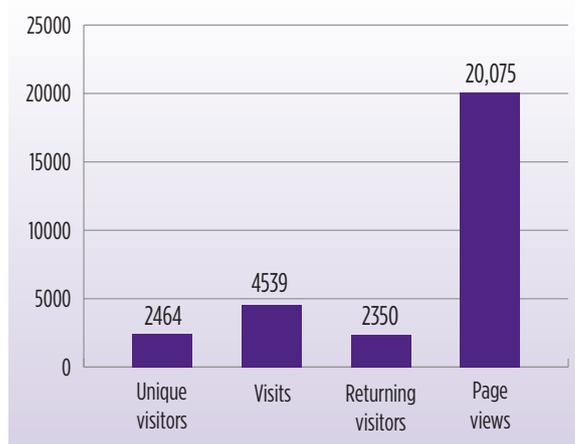
CMHDARN has recently finalised its report to the NSW Ministry of Health after the completion of its three year funding period. An assessment of the project across those years suggests a positive and encouraging impact of the CMHDARN activities. Over this period, CMHDARN has successfully engaged with workers in the mental health and drug and alcohol community managed sectors (CMOs), academic researchers in universities and other research institutes through a program of quality activities. This cross sector collaboration is also reflected in CMHDARN's governance and reference group support structures, which have representation from MHDA sectors, academics, consumers and carers. Members of these groups have provided ongoing and valuable guidance to the project. In recognition of its work, CMHDARN received a Certificate of Commendation in the category of Cross Sector Collaboration in the NSW Mental Health Month Awards in October 2013.

Some examples of achievement across the three year period include:

### Participation in CMHDARN

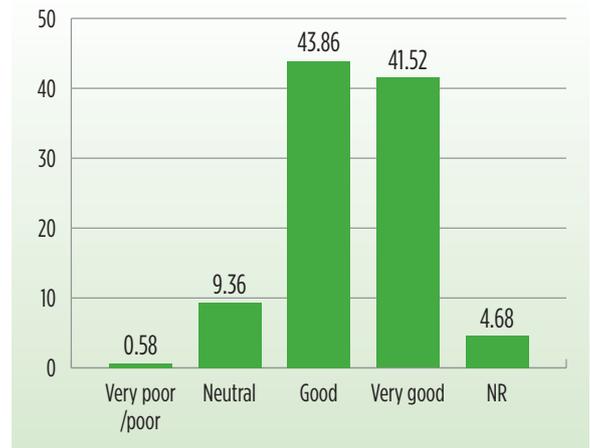
234 people are currently on the formal CMHDARN membership list (substantially up from December 2011 when 94 people identified as being part of the Research Network). There are at least 50 other people who have participated in at least one activity. There are around 2,500 people who have accessed the website since it went live in September 2012, with over 20,000 page views (see Figure 1) thus demonstrating a keen interest in CMHDARN.

Figure 1: Total website use Sept 2012 – Dec 2013



- The **CMHDARN Research Forum program** was rated by around 85% of those completing feedback forms as being very good or good (see Figure 2).

Figure 2: Overall rating of research forums



### Collaboration across MHDA and academic research sectors

45 academics from 11 universities have supported the CMHDARN activity over the last three years. Table 1 outlines the ways in which academic researchers have participated in CMHDARN activities.

### CMHDARN Research Seeding Grants Program

This was a major activity of CMHDARN, and resulted in 16 projects being funded and successfully completed. Recipient organisations reported on many achievements through this program. Some outcomes of these grants include:

- **Dissemination of results:** these grants have resulted in 12 conference presentations reporting on outcomes of these projects, whilst five papers have been submitted for publication in peer reviewed journals.
- **Research Capacity:** Reflections from academics and the CMHDARN Evaluation sub-committee members agreed that all NGOs that participated in the Seeding Grants program have improved their confidence and that they are much more 'research ready'. Of CMO survey respondents, 90% agreed or strongly agreed that the seeding grant increased their research capacity.

Table 1: Number of Academic Researchers by Area of Involvement with CMHDARN

| Area of Involvement                           | Number of people | Number of universities |
|---|------------------|------------------------|
| Attendance at CMHDARN activity                | 32               | 11                     |
| Presentations at CMHDARN activity             | 13               | 5                      |
| Research Seeding Grant partner                | 15               | 8                      |
| CMHDARN Project Reference Group member        | 4                | 4                      |
| <b>TOTAL instances of involvement</b>         | <b>64</b>        | <b>28</b>              |
| Number of individual academics involved       | 45               |                        |
| Number of individual universities represented |                  | 11                     |

- Enhanced capacity to deliver services to consumers:** Respondents to the CMO survey agreed that their research findings enhanced the capacity of their organisation to deliver services to consumers in a variety of ways, including 'in general' (90%); with AOD issue (90%), with MH issues (80%), and with Co-existing issues (80%).
- Research into Practice:** 60% of CMOs reported that they would be integrating the findings from the project into their service provision.

### CMHDARN Community Research Mentoring Project

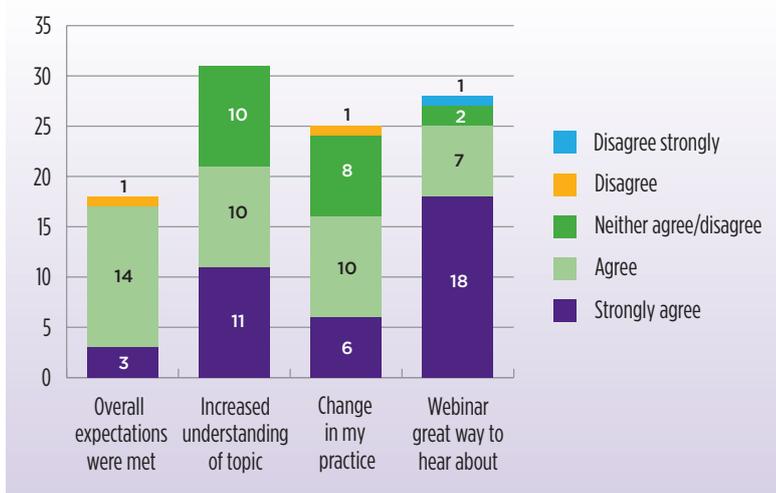
CMHDARN and the NHMRC Centre for Research Excellence in Mental Health and Substance Use (CREMS) have reached agreement to offer research mentoring to workers based in community managed organisations. Currently applications from would-be mentees are being assessed for matching with mentors. This unique project will provide mentees with high level support for their work based research related activities.

### CMHDARN Reflective Practice Webinars

CMHDARN has attracted almost 200 registrations for its four events, with forums addressing research relating to coexisting issues within a mental health service, stigma and discrimination, implementation science and working with young people with complex and coexisting needs (see Figure 3).

In 2013, the CMHDARN Steering Committee decided a priority theme would be 'implementation science' (i.e. the language and processes relevant to utilising research results into their practice and organisational culture). This decision was made in the belief that the CMHDARN could and should play an important role in promoting improved service delivery

Figure 3: Reflective practice webinars outcomes



and outcomes for consumers by bringing the concepts and practices of implementation science to the MHDA sectors. This focus was maintained through all workshops, research forums, reflective practice webinars and internet based resources for the year.

A very positive outcome for 2013 was the securing of another year's funding through the NSW Mental Health Commission (NSWMHC). One thing that has become very obvious to those of us involved with CMHDARN is that there is a growing and ongoing need for support in developing and engaging in research related activity by CMOs. With a variety of abilities and capacities within and across the sectors, CMHDARN hopes to continue to play a role in facilitating support the development of research related skills and knowledge.

For further information on CMHDARN, contact the Project Officer, Deb Tipper, on 02 9555 8388 ext 135 or [deb@mhcc.org.au](mailto:deb@mhcc.org.au) and visit the website [www.cmhdaresearchnetwork.com.au/](http://www.cmhdaresearchnetwork.com.au/)

## Community Care Northern Beaches



COMMUNITY Care Northern Beaches (CCNB) has been operating as a community care provider since its incorporation in 1994. Over the years, the organisation has grown from a provider of a single program, *Community Options*, within the Manly, Warringah, Pittwater area, to one that auspices a range of programs across Northern Sydney for a diverse set of stakeholders.

CCNB was successfully funded as the lead organisation for the Sydney North Shore and Beaches Partners in Recovery (PIR) Project in 2013. CEO, Sharon Grocott, spoke with MHCC about the rewards and challenges of building partnerships for improved service provision.

### **VFP** How is PIR working in the Northern Beaches area and beyond?

PIR assists in facilitating better co-ordination, improved referral pathways, communication and streamlined access to services and supports. Outcomes for consumers are maximised as a result of collaborative and integrated service provision. PIR promotes a community based recovery model to underpin clinical and community support services. This includes improving the recovery focal point within the whole service system. Under the initiative, we are developing and working towards shared goals and outcomes with multiple stakeholders.

In our region, PIR Facilitation is subcontracted to three Community Managed Organisations: New Horizons, Uniting Care and the Schizophrenia Fellowship NSW. This model of facilitation, developed through sector consultation, maximises existing sector knowledge and enables separation of sector development and governance from service delivery. This model maximises cross-sector resource sharing and up skilling, and reduces fragmentation and duplication in facilitation functions. PIR utilises a flexible funding model to enable innovation and flexibility in service provision in response to individual needs.

One of the best outcomes of PIR is the sharing of best practice through opportunities such as actively sharing resources and tools across PIR regions.

### **VFP** What are the current challenges?

One of the challenges for PIR staff is that organisations can sometimes operate in silos. This can often be due to historical and cultural issues. It can be difficult to make the shift to see a different way of working with each other. Sometimes this is due to a lack of understanding about roles and responsibilities. It can also be due to varied practices and processes. For instance, different referral processes can make it much harder for carers and people experiencing mental illness to navigate the service system.

One of the critical issues the initiative faces is the three year funding cycle. Capacity building will be the key in ensuring that the outcomes of PIR are sustainable.

Another challenge is competitive tendering, which creates an environment that can actually impede collaboration. However, even in the initial stages of PIR implementation, there is consensus that we all have more to gain from sharing than we do from siloing, and this is both true for us as providers, but most importantly, in relation to the experience of consumers.

Our vision is that the success of PIR and the collaborative underpinnings of the model will precipitate collaboration and partnership requirements within future funding models. This vision would see organisations that partner and collaborate having a competitive edge over siloed organisations.

### **VFP** What approach is CCNB taking to assess people's individual or complex needs?

Our focus is on 'wrap around' care which will mean that services are holistic and tailored to individual needs. This also includes definitions of unique recovery journeys.

The assessment process is comprehensive, flexible and responsive. It relies on capacity to link and network with other providers who specialise. CCNB is committed to providing services that reflect what consumers, carers and the broader service system want to see. Our approach is about recognising that individuals often hold the key to what needs to be done to improve their wellbeing in ways that are important to them. It's about acknowledging that people are at different stages of their recovery journey.

We undertake assessment through a storytelling methodology whereby consumers' stories are heard and respected in their entirety. This allows discussion around what the consumer sees as

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their most pressing concerns, strengths and needs, and builds trust in the assessment and support relationship.

There are opportunities for working together more broadly at a State level on issues such as the development of clinical governance frameworks. We believe such initiatives build broader system capacity and result in better outcomes for consumers. Laurie Bassett, PIR Manager at CCNB, currently co-chairs a working group with representation from other PIR lead agencies across the State, looking at the development of a shared clinical governance framework, as an example.

Where systems gaps are known, we work in partnership with other regional and state providers to build strategies to address these for our community. CCNB and PIR have embarked on a number of capacity building initiatives in social housing, recovery orientated training and development, and activities that specifically focus on improve outcomes for Australia's First People and people identifying as Lesbian, Gay, Bisexual, Transgender and/or Intersex for example.

**VFP** What do you bring to the role of chief executive officer?

My previous experience of working across sectors including education, business, community organisations, and government to build sustainable partnerships has been very valuable. Over the last couple of years I have chaired a NSW Mental Health Working Group for the Partnership Broker NSW Network. I mapped best



Susan Moylan-Combs and Professor Dennis Foley commence the CCNB Partners in Recovery launch with a traditional smoking ceremony.

**Our approach is about recognising that individuals often hold the key to what needs to be done to improve their wellbeing in ways that are important to them. It's about acknowledging that people are at different stages of their recovery journey.**

practice partnerships across the State and this provided useful insight into the challenges of making partnerships work.

Partnerships can also be the vehicle to enable organisations to think differently which can result in service innovation. You often find that greater traction can even be gained to address systemic issues such as gaps in social housing.

## THE PHOTOVOICE PROJECT

### Capturing images of recovery to better understand a life with mental illness

The PhotoVoice Project worked with a group of passionate consumers, to capture photographic images of Recovery from the perspective of the person living with mental illness. PhotoVoice utilises an action research methodology, using the process of photography and imagery to describe and share human experience.

The project involved the provision of cameras, training and resources. The resulting images have been displayed around the CCNB offices as a constant visual reminder of the uniqueness of people's recovery journeys.

The images will also be displayed in a roving exhibition.

For more information about the PhotoVoice Project or CCNB's other programs and services visit [www.ccnb.com.au](http://www.ccnb.com.au) or call 1300 002 262.



*Stillness and Peace*  
from the PhotoVoice Project

## Equality, Capacity and Disability in Commonwealth Laws

IN THE wake of the NDIS, the establishment of the National Disability Insurance Agency (NDIA) and the assented legislation underpinning policy and practice frameworks, the Australian Law Reform Commission (ALRC) has been investigating and consulting on “Equality, Capacity and Disability in Commonwealth Laws”. Much of their work has centred on how well the legislation articulates the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which Australia ratified in 2006.

For example, supported decision-making is quite loosely defined and articulated in the scant literature, but is referred to UNCPD, Article 12(3) on Equal Recognition before the Law, as providing that the: *‘states parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity’*.

Supported decision-making provides an alternative to guardianship or other people taking on decision-making roles. Decision-making should be supported, not substituted. In supported decision-making, consumers are actively helped to identify their values, goals and choices.

Difficulties frequently occur in the mismatch between state and Commonwealth law and in its submission, MHCC recommends the inclusion of supported decision-making in the NSW *Mental Health Act* (2007) (MHA); the NSW *Guardianship Act* (1987) and the NSW *Disability Services Act* (1993) (DSA) now updated as the *Disability Inclusion Bill* (2014), so that that all legislation aligns with Commonwealth legislation. This will then go some way towards meeting the stated commitment towards embedding the rights of persons with disabilities in both state and Commonwealth law.

Another important point raised in MHCC’s submission is that the National Disability Strategy 2010–2020<sup>1</sup>, identifies areas for future action in relation to rights, protection, justice and legislation. We strongly support these identified areas because people with psychosocial disability are over-represented in the justice system whether as complainants, litigants, defendants, or victims.

Whilst Australian governments fund some legal services specifically for people with disability and Australian courts have begun to introduce some disability access schemes<sup>2</sup>, people with mental health conditions often experience difficulty in participating in the legal system.



Characteristically, this group encounters significant barriers, with many finding access to justice too difficult, intimidating or inadequate. As a result, consumers are often left without legal redress.<sup>3</sup>

*‘Underfunding of public legal services has resulted in a significant tightening of eligibility criteria. As a result, legal representation is primarily available only to the very poor and generally only in criminal matters’* (PWD, 2013)<sup>4</sup>. MHCC therefore strongly urge that the Commonwealth support increased access to legal advocacy to protect the rights of people with disability.

The full MHCC submission can be accessed at [www.mhcc.org.au/media/34539/alrc\\_-\\_equality\\_capacity\\_\\_\\_disability\\_in\\_commonwealth\\_laws.pdf](http://www.mhcc.org.au/media/34539/alrc_-_equality_capacity___disability_in_commonwealth_laws.pdf)

For further information contact Corinne Henderson, at [corinne@mhcc.org.au](mailto:corinne@mhcc.org.au)

### Endnotes

1. Council of Australian Governments, National Disability Strategy 2010 -2020, p.41, [http://www.dss.gov.au/sites/default/files/documents/05\\_2012/national\\_disability\\_strategy\\_2010\\_2020.pdf](http://www.dss.gov.au/sites/default/files/documents/05_2012/national_disability_strategy_2010_2020.pdf)
2. NSW Attorney General's Department, 'Disability Strategic Plan 2006-2008: Summary', <http://www.diversityservices.lawlink.nsw.gov.au/agdbasev7wr/divserv/documents/pdf/dsponline.pdf> and Victorian Department of Justice, 'Disability Action Plan 2009-2011', <https://assets.justice.vic.gov.au/justice/resources/b860cfef-023a-4944-b033-7dd292203310/disability+action+plan+2012-2016.pdf>
3. Submissions provided during the CRPD Shadow Report consultations in SA, NSW & WA in November 2009.
4. People with Disability Australia (PWDA), 2013, Submission Productivity Commission Issues Paper: 'Access to Justice Arrangements'.

## Research findings of physical health project

**Research outcomes from the MHCC physical health research project highlight the need for routine systems to be established within community organisations which support consumers to manage their physical health needs.**

MHCC, in partnership with the University of Sydney and funded by the Ministry of Health, have just completed a research project to learn more about physical health programs that are being delivered through NSW Community Managed Organisations (CMOs) supporting people with mental health conditions.

This six month project aimed to clarify:

- the extent or range of the activities offered;
- if and/or how effectiveness was being measured;
- perspectives of various stakeholders; and
- how well current practices align with best emerging and available evidence.

The international literature review unquestionably demonstrates that people living with mental illness are much more likely than the general population to experience a number of serious and life threatening physical health conditions. Equally, the literature shows that they receive less access to and poorer quality of health care for those physical conditions than the general population.

Survey and interview results indicate that the current practices and physical health initiatives within the NSW CMO sector broadly mirror those in the literature. That is, there are a growing number of organisations running a diverse range of physical health programs and activities. A significant challenge identified in the study was the capacity of many staff (in terms of both resources and knowledge) to measure outcomes and thus evaluate program effectiveness.

The literature shows that internationally, there is still a lack of systemic, routine appraisal of physical health needs of people living with mental illness. The study demonstrates that this too remains the case within the CMO sector and health sector more broadly in NSW. Whilst a few CMOs have formal and specific requirements for supporting consumers using their service to address their physical health needs, this is the exception rather than the rule. Most organisations leave physical health support decisions to the discretion of individual staff members.

While staff participants discussed the value of treading slowly, developing a rapport and selecting 'just the right time' to discuss physical health needs and risks, in reality this meant that only some consumers had access to physical

PEOPLE WITH mental illness have a life expectancy approximately 25 years less than that of the general population. Incidence of diabetes in persons with persistent mental illness is four times that of the general population; of cardiovascular disease three times that of the general population and weight gain on commonly prescribed medication is around 40% (e.g. De Hert, Correll, & Cohen, 2011; Mental Health & Drug & Alcohol Office, 2013).

health information and support. Again reflecting the broader literature, consumers talked about having to actively seek physical health assistance from mental health care professionals and GPs who only focused on their mental health issues. In parallel, consumers discussed the challenges of working with physical health focussed providers when they had a poverty of understanding in terms of mental illness.

The MHCC *Physical Health Research Summary Report and Recommendations* are now available at [www.mhcc.org.au](http://www.mhcc.org.au) (search 'physical health').

The results will also soon be written up as an academic publication in peer-reviewed literature.

## A RECIPE FOR IMPROVED PHYSICAL HEALTH

PEOPLE WITH a serious mental illness have a significantly reduced life expectancy, with premature cardiovascular disease a significant cause. Lifestyle factors including poor diet and low levels of physical activity are key contributing factors that are modifiable through evidence-based exercise and nutritional prescriptions.

Exercise is also known to have strong anti-depressive and anxiolytic benefits and can play a dual role in simultaneously improving both physical and mental health outcomes for people experiencing mental illness. Allied health professionals, such as accredited exercise physiologists (AEPs), are well placed to deliver clinical exercise programs and lifestyle advice to people with serious mental illness.

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### What is an accredited exercise physiologist and how do I access services?

AEPs provide clinical exercise interventions and lifestyle modification programs for people with complex and chronic conditions. AEP services are accessible through a range of government and private sector programs. For example, the Medicare program: *Access to Allied Health Individual Services for patients with a chronic medical condition and complex care needs*, provides Medicare rebates for certain allied health services (including exercise physiology) to patients with chronic conditions and complex care needs on referral from their GP.

Further, Exercise & Sports Science Australia (ESSA) in conjunction with South West Sydney Medicare Local (SWSML) manages the Healthy Eating Activity and Lifestyle (HEAL™) program. HEAL™ is a lifestyle modification program that enables participants to develop lifelong healthy eating and physical activity behaviours. Resources for this program have been adapted



to target disadvantaged populations, including people with mental illness.

For further information on HEAL™ or AEPs please contact ESSA at [www.essa.org.au](http://www.essa.org.au) or Louise Czosnek at [louise.czosnek@essa.org.au](mailto:louise.czosnek@essa.org.au)

## Supporting your mental health service on their quality improvement journey

QUALITY Innovation Performance (QIP) is a not-for-profit certification and accreditation organisation, dedicated to supporting health and community service organisations to manage risk and improve service quality.

QIP was formed in 2012 as a result of a merger between Australia's four major primary health care accreditation bodies – Quality in Practice, the Quality Improvement Council (QIC), Quality Improvement and Community Services Accreditation Inc. (QICSA) and Quality Management Services (QMS).

QIP has been assessing community managed mental health services for almost twenty years and now offers mental health services the flexibility of two accreditation pathways:

1. **Building Quality in Mental Health Services:** This accreditation product has been designed for mental health services undergoing accreditation for the first time and is aimed at assisting services to establish management

**By becoming accredited your organisation is able to demonstrate a commitment to quality.**

systems aligned to the requirements of the National Standards for Mental Health Services (NSMHS). Clients complete a self-assessment using an online accreditation tool, AccreditationPro. Accreditation is awarded for a two-year period based on a desktop assessment of evidence provided within the self-assessment.

2. **Quality Plus in Mental Health Services:** This accreditation product has been designed to meet the needs of mental health services that are already accredited against the NSMHS or another quality framework and/or who have mature quality systems. Clients complete a self-assessment using AccreditationPro. Accreditation is awarded for a three year period based on an on-site assessment.

QIP offers a wide range of resources and accreditation support to ensure accreditation is a positive and developmental process with both accreditation pathways. By becoming accredited your organisation is able to demonstrate a commitment to quality and allows you to gain a valuable independent measure of the quality of service provision.

For more information on how accreditation can help your organisation visit [www.qip.com.au](http://www.qip.com.au)

## Disability Support Pension changes ahead

AS DETAILS emerge about the implications of the Commonwealth Government's Commission of Audit, it is expected that changes to the Disability Support Pension (DSP) will be considered, and tightening of eligibility conditions could form a component of this. The Minister for Health, Peter Dutton, has commented a number of times on his 'surprise' at the number of people on the DSP for psychosocial disability. Prime Minister Tony Abbott has commented previously on his view that the DSP has failed to move people with disabilities back into the workforce.

Little evidence has been provided on the cause of the rising proportion of people on the DSP for psychosocial disabilities (currently 31.3 per cent have psychological or psychiatric conditions), however it is unlikely that this constitutes a 'blowout' as has been suggested by the Minister for Health. The same statistics in the January 2014 document provided to the Senate Estimates Committee showed the number of people claiming the DSP has dropped 1 per cent since 2011.

Regardless of the reason for the change in DSP claims, it is clear that people with mental health conditions are in the sights of the Government's Commission of Audit. As the DSP appears to be under review, the MHCC believes that such a review should include the following considerations:

- Changes to the DSP that result in higher eligibility criteria should not be used as a justification to modify needs assessment by the National Disability Insurance Agency. This would in effect cause a 'double whammy.'
- Employment support options should also be provided for people with mental health conditions who find themselves no longer covered by the DSP. An example of this could be opening access to PHaMS employment to cover the vulnerable period that would exist when DES supports cease.
- Employer support programs should be developed to better manage employees with mental health conditions and episodic illnesses, which would lead to fewer DSP claims.
- Social enterprises for people unable to cope with mainstream employment options should continue to receive support from the Government.
- The Day to Day Living (D2DL) program should be continued to provide people with a supported pathway through skills and confidence development towards unsupported employment.



RichmondPRA's new social enterprise printing outlet offers employment opportunities to people living with mental health conditions.

**Regardless of the reason for the change in DSP claims, it is clear that people with mental health conditions are in the sights of the Government's Commission of Audit.**

The capture of Commonwealth mental health programs as an 'in kind' donation to the NDIS has led to the worrying development of an emerging gap for people with lower levels of psychosocial disability who may no longer be eligible for previous mental health programs. As these people lose access, there will be a need for additional supports to compensate. Without this we will be likely to see an increase in hospital admissions and potentially more contacts with the justice system.

Meanwhile, possible funding cuts to Medicare and the NDIS are also being publicly discussed by the Government in the context of the Commission of Audit. MHCC hopes that the Government will be mindful of the compounding negative effects that may occur should multiple budget tightening measures hit the particularly vulnerable group of people with psychosocial disability at the same time.

Did you miss our last issue?

View From the Peak is available online at [www.mhcc.org.au](http://www.mhcc.org.au)



## Hearing voices: journeys to understanding

**Arana Pearson has been delivering training to the mental health sector for nearly 20 years about the experience of hearing voices. He recently spoke with MHCC about the changing approach to working *with* voice hearers in Australia.**

THE FACT people hear distressing voices is core business in mental health. Yet there remains much fear, discrimination and poor clinical outcomes for people who hear voices. Too many voice hearers in Australia have never yet heard about recovery and many of us still do not have the hope we may recover.

### Why haven't voice hearer's experiences been heard?

Clinicians were taught 'not to enter the psychosis' and to distract patients from their experience rather than to talk about the content of the voices. Counsellors and psychologists 'best practice' guidelines specifically excluded people who hear voices from receiving their services. Support workers were unclear whether talking with someone about the content of their voices was 'clinical work' or not.

Most of us who hear voices have experienced how risk assessment is a major focus. Much of this interest seems to be about whether the voices are commanding a person to harm themselves or others. Although risk assessment is an important aspect of good practice, there are other aspects to being a voice hearer that help a person to recovery. This is a key difference between a service perspective and a voice hearer perspective.

### Tell us more about this approach.

A peer group approach is about creating a safe place where voice hearers can explore their own meaning of their personal experience. There is no 'right' or 'wrong' about a personal experience, and the acceptance people find in such a supportive group contributes to a personal recovery. Sometimes an abusive voice is experienced alongside positive voices. A positive voice can be a protective agency in a voice hearer's life. Working with the voices is then a different approach to protecting people from the harm of negative voices. Now, peer lead approaches in partnership with clinical and community services, are leading a renewed energy for engaging with people who hear voices.

### How is the World Hearing Voices Congress furthering this?

The 2013 Congress sought to be a safe place in which voice hearers, clinicians, family members, researchers and indigenous people could discuss

these matters. The congress was hosted by Voices Vic (a voice hearer lead organisation auspiced by Prahran Mission in Melbourne) in partnership with INTERVOICE (The International Network for Training, Education and Research into Hearing Voices).

(I had) a chance conversation with Dr Simon McCarthy Jones (a researcher and author on the topic of voice hearing) after a session he had presented on day one of the congress. Simon suggested to me that peer support and voice hearer approaches were more concerned with utility about what works, whilst he was more occupied with evidence, and that these two areas of knowledge were quite different. This conversation led me to alter my own keynote address to explore how the utility of our personal story might practically work in the context of the apparent absurdity of the idea that I hear voices that no-one else can hear.

I have been delivering training to the mental health sector about the experience of hearing voices for many years. I felt privileged to participate in this event, which was bigger than I could ever have imagined 20 years ago. However, the success of a conference is just one more step along a path to changing practice.

Mental health systems continue to hope for an integrated system yet we continue to hear of a clinical vs. non-clinical divide that is a barrier to cooperative practice and which fragments voice hearer opportunities for recovery. Peer support services look to professionalise boundaries around personal recovery experiences without examining the power of non-professional natural supports.

I am not yet sure we have achieved a change in practice where all mental health workers understand how to initiate and support a conversation about hearing voices. Without a profile of the voice hearer experience, a mental health worker has failed to record a history that effectively places the clinical work within a personal context.

I come away from the great experience of this event with renewed energy to continue my work up-skilling all mental health workers in voice profiling as we all continue to learn more deeply what the experience means.

**The Hearing Voices Approach** was born out of a conversation between Professor Marius Romme and a voice hearer Patsy Hage. In 1987 they appeared on Dutch television with journalist Dr Sandra Escher to speak about voice hearing and asked people who heard voices to contact them.

Following the TV program 450 people who heard voices responded and this response led to the establishment of the first hearing voices self-help group.

The first **Hearing Voices Congress** was held in Holland in 1988, aiming to raise awareness of the voice

hearing experience. This ultimately led to a worldwide movement that works towards supporting the recovery of those who are distressed by hearing voices.

Around the world, groups of voice hearers meet and talk, sharing viewpoints and strategies to support each other, telling their stories and exploring ways to work with, rather than against, their voices in order to reclaim control and rebuild their lives.

Hearing Voices Movement in NSW: [hvna.net.au](http://hvna.net.au)

Melbourne Hearing Voices declaration:  
[www.prahranmission.org.au/declaration](http://www.prahranmission.org.au/declaration)

## Valuing consumer experience

ANOTHER KEY contributor to the success of the World Hearing Voices Congress was Melbourne-based Indigo Daya, whose keynote address *Making sense of my voice in the context of childhood trauma: What helped, what got in the way*, was a highlight of the event.

MHCC Learning & Development is excited to offer three of Indigo's popular workshops as part of the Professional Development Series in 2014. These workshops are specifically designed to support organisations to better engage with consumers on every level; from program development and delivery, to supporting and managing a consumer workforce.

Drawing on her lived experience of mental distress and 15 years as an on-again-off-again consumer of mental health services in Victoria, Indigo injects the consumer perspective into every aspect of the training she has developed.

"After years of life as a revolving door psychiatric patient - heavily medicated, unemployed and without hope - I finally found a therapist and a keyworker who saw my potential rather than my limitations - from here the real recovery work began."

**“ When workers are willing to join us for part of the [recovery] journey, and let down some of the unnecessary boundaries, it forms a powerful learning connection. As workers you can be great role models for us, and coaches and mentors, too. ”**

(Read about Indigo's recovery journey here: [www.indigodaya.com/about/indigos-recovery-story/](http://www.indigodaya.com/about/indigos-recovery-story/))

In addition to her work as a trainer, writer, public speaker and consultant, Indigo manages the consumer led organisation, Voices Vic. She has studied with many of world's consumer leaders, and continually strives to bring about a better mental health system where recovery and self-determination are the norm and not the exceptions.

### Indigo's workshops

#### Lighting the Spark - working with goals, motivation and recovery

This interactive half-day workshop is a chance for support workers to enhance their skills in working with goals, motivation and recovery.

#### Nothing About Us, Without Us - building consumer participation and leadership

This half-day workshop is designed to help organisations to facilitate greater consumer participation and leadership in the provision of programs and services.

#### Supporting and Managing a Consumer Workforce

Mental health services are increasingly hiring consumer and peer workers for their lived experience. This two day workshop will develop the skills and knowledge needed by team leaders and managers to understand, support and effectively manage consumer workers.

Contact [training@mhcc.org.au](mailto:training@mhcc.org.au) for more information or to enrol.



## MHCC ACTIVITIES – AT A GLANCE

### Key Projects – details at [www.mhcc.org.au](http://www.mhcc.org.au)

- Grants Management Improvement Program - Ministry of Health Mental Health Program Approach
- Peer Work Qualification Project and Peer Worker Qualification training materials development
- Community Mental Health Drug and Alcohol Research Network (CMHDARN)
- Medicare Locals Engagement
- Monitoring Safeguards Mechanisms – NSW Ombudsman's Office
- NSW Mental Health Rights Manual Review
- National Directions in Mental Health Workforce Development (on behalf of CMHA)
- National Disability Insurance Scheme analysis and impacts
- National Outcome Measurement and Minimum Data Set Projects (on behalf of CMHA)

- Physical Health Research Project
- ROSSAT Psychometrics Project
- Sector Benchmarking Project
- Trauma-Informed Care and Practice: National strategic direction
- Trauma-Informed Care and Practice Organisational Toolkit (TICPOT)
- Partners in Recovery Support Facilitator training package

### Key Submissions/Comment:

- NSW Law Reform Commission – Discussion Paper 4. Reintegration into community and management on parole
- Australian Law Reform Commission – Issues paper 44. Equality, Capacity and Disability in Commonwealth Laws
- Department of Health – review of Medicare Locals (MLs)
- HCCC submission – false and misleading health information review

- Disability Inclusion Bill
- National Mental Health Commission – National Mental Health Review (CMHA)

### MHCC facilitated and/or presented at the following events:

- MHCC AGM and Big Issues Forum 3/12/2013
- Building the Community Sector Forum (joint forum with NSW MHC) 19/2/14
- NDIS Mental Health 'Community of Practice' (COP) Forum on 23/1/14
- Presentation to NDIS Organisational Readiness Workshop hosted by MH Council of Tasmania, MHCA and NDS 06/02/2014
- Meet Your Neighbour events (Central Coast 20/01/2014, Nowra 06/02/2014, Marrickville 13/02/2014, Parramatta 18/02/2014, Newcastle 24/02/2014)

## MHCC STAFF AND CONTACT DETAILS

### Mental Health Coordinating Council Inc.

is the peak body for community managed organisations working for mental health in New South Wales.

Ground Floor, Building 125  
Corner Church and Glover Sts,  
Lilyfield 2040  
PO Box 668 Rozelle NSW 2039  
Telephone: 02 9555 8388  
Fax: 02 9810 8145  
[www.mhcc.org.au](http://www.mhcc.org.au)  
email: [info@mhcc.org.au](mailto:info@mhcc.org.au)

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| Position                                    | Name                | Email  |
|---|---------------------|--|
| Chief Executive Officer                     | Jenna Bateman       | <a href="mailto:jenna@mhcc.org.au">jenna@mhcc.org.au</a>                           |
| Senior Policy Advisor                       | Corinne Henderson   | <a href="mailto:corinne@mhcc.org.au">corinne@mhcc.org.au</a>                       |
| Operations and HR Manager                   | Erika Hewitt        | <a href="mailto:erika@mhcc.org.au">erika@mhcc.org.au</a>                           |
| Senior Policy Advisor Sector Development    | Tina Smith          | <a href="mailto:tina@mhcc.org.au">tina@mhcc.org.au</a>                             |
| Policy and Partnerships Officer             | Stephanie Maraz     | <a href="mailto:stephanie@mhcc.org.au">stephanie@mhcc.org.au</a>                   |
| Senior Policy Officer                       | Tully Rosen         | <a href="mailto:tully@mhcc.org.au">tully@mhcc.org.au</a>                           |
| Project Officer Research Network            | Deb Tipper          | <a href="mailto:deb@mhcc.org.au">deb@mhcc.org.au</a>                               |
| Compliance and Quality Coordinator          | Sheena Lee          | <a href="mailto:sheena@mhcc.org.au">sheena@mhcc.org.au</a>                         |
| Community Engagement Officer                | Carrie Stone        | <a href="mailto:carrie@mhcc.org.au">carrie@mhcc.org.au</a>                         |
| Promotions Officer                          | Lenny Pelling       | <a href="mailto:lenny@mhcc.org.au">lenny@mhcc.org.au</a>                           |
| IT Officer                                  | Ian Bond            | <a href="mailto:ian@mhcc.org.au">ian@mhcc.org.au</a>                               |
| Finance Officer                             | Jill Dimond         | <a href="mailto:jill@mhcc.org.au">jill@mhcc.org.au</a>                             |
| Reception and Office Admin                  | Colleen Mosch       | <a href="mailto:info@mhcc.org.au">info@mhcc.org.au</a>                             |
| Learning & Development                      |                     |  |
| Manager LD                                  | Simone Montgomery   | <a href="mailto:simone@mhcc.org.au">simone@mhcc.org.au</a>                         |
| Training Services Team Leader               | Jacqui Moreno Ovidi | <a href="mailto:jacqui@mhcc.org.au">jacqui@mhcc.org.au</a>                         |
| Project Liaison and Development Team Leader | Chris Keyes         | <a href="mailto:chriskeyes@mhcc.org.au">chriskeyes@mhcc.org.au</a>                 |
| Training Logistics Coordinator              | Lisa Van Praag      | <a href="mailto:lisa@mhcc.org.au">lisa@mhcc.org.au</a>                             |
| Senior Admin Officer                        | Joanne Timbs        | <a href="mailto:joanne@mhcc.org.au">joanne@mhcc.org.au</a>                         |
| Student Support and Admin Officer           | Nicole Cother       | <a href="mailto:nicole@mhcc.org.au">nicole@mhcc.org.au</a>                         |
| Partnerships Admin Officer                  | Rainbow Yuen        | <a href="mailto:rainbow@mhcc.org.au">rainbow@mhcc.org.au</a>                       |
| Admin Assistant                             | Melinda Shipp       | <a href="mailto:training@mhcc.org.au">training@mhcc.org.au</a>                     |
| Aboriginal Project Admin Officer            | Liesl Homes         | <a href="mailto:aboriginalprojects@mhcc.org.au">aboriginalprojects@mhcc.org.au</a> |
| Online Learning Officer                     | Kat Fardian         | <a href="mailto:kat@mhcc.org.au">kat@mhcc.org.au</a>                               |
| Short Course Coordinator                    | Lorna Downes        | <a href="mailto:lorna@mhcc.org.au">lorna@mhcc.org.au</a>                           |