



TheMHSConference  
26-29August2014Perth  
The Mental Health Services Conference Incorporated (TheMHS)



# Book of Abstracts

## Friday 29 August

**S081 Keynote: Ken Thompson****29/8/2014 From: 900 To: 1000 Venue: Riverside Theatre****Keynote Presentation: Putting Recovery into Practice: Sharing a Personal and Professional Journey****Ken Thompson**

'Sadness shared is halved, joy shared is doubled' Putting recovery into psychiatric practice has been a significant challenge. It's clear that the process of recovery belongs to the person who's recovery it is. It is entirely personal. But it can be difficult and hard work, and a helping hand and a variety of tools can be useful. Traditional psychiatric services have long been ambivalent about personal recovery and the exercise of personal agency and capability by people 'being cared for'. While the idealistically stated goal of psychiatric care has been to help people return to their full capacities and decision making abilities, in practice many approaches to providing care have substituted the care providers' desires and choices for those of the person in need of help- often to the point of coercion. At the same time, sometimes safety is a compelling need. What, if anything, can be salvaged from past practice as we move to develop services that support, rather than stifle, personal recovery? What needs to be discarded? And what needs to be created for the first time? How can recovery oriented practitioners deal with the thorny issues of danger and coercion? These concerns have increasingly been at the heart of the practice of psychiatry- including my own. In the United States, the Recovery to Practice initiative, sponsored by the Substance Abuse and Mental Health Administration (SAMHSA) has been focused on these questions. This evolving American approach will be described to see what we might usefully share to find the path forward on both sides of the Pacific.

**S082: Featured Symposium: Mental Health Commissions: Expectations and Realities (location: Riverside Theatre)****29/8/2014 From: 1030 To: 1230 Venue: Riverside Theatre****Featured Symposium 2 hrs****Mental Health Commissions: Expectations and Realities****10.30am: Hon. Helen Morton****11.00am: Tim Marney Lesley Van Schoubroeck David Butt Julie Robotham**

New Zealand has had a Mental Health Commission for many years while Australia's first Mental Health Commission was initiated in Western Australia 4 years ago. Today there are 3 state and one national Commissions in Australia. Mental health consumers, families, clinicians and managers have welcomed this initiative in mental health services. But is it now time to look at where we have come from, what can be expected of MH Commissions and how different models of Commission provide an impetus toward continually improving MH Services? Several perspectives will be presented in this session. **Speakers are:** Tim Marney, WA Commissioner for Mental Health; Lesley Van Schoubroeck, Qld Commissioner for Mental Health; David Butt, CEO, Australian National Commission; Julie Robotham, Communications Manager, NSW Mental Health Commission. Each speaker will speak for 15 minutes, followed by audience questions and discussion. **Tim Marney: Mental Health Commission – The WA Way. Lesley Van Schoubroeck: Shaping Expectations:** Lesley will reflect on the first year of the Mental Health Commission in Queensland, and the challenge of meeting multiple expectations. The long lead time from consultation to implementation has raised expectations of what the agency should be doing, including some roles outside the legislative mandate of the agency. Lesley will highlight some of the strategies being put in place to both shape and meet expectations. **Julie Robotham: The NSW experience - keeping the reform journey on track:** The Mental Health Commission of NSW was established in 2012 as an independent statutory body that advises

Government. It is explicitly responsible for elevating the consumer voice in the policy conversation around mental health, and a principal challenge is to find ways to break out of a self-perpetuating model of over-investment in hospital-based services and embed a community approach to mental health support. In its first two years the Commission has consulted exhaustively to develop a blueprint for a system of mental health support that has at its heart the concerns of people who live with mental illness. As the Strategic Plan for Mental Health in NSW is finalised for release, along with the NSW Government's response, the Commission's new challenge will be to set the pace for an ambitious but realistic long-term program of reform targets that keeps faith with the wishes of the community, and that Government can also commit to and achieve.

**S083 Keynote Q&A: Ken Thompson**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 01**

**Keynote Q&A (Session webcast)**

**Ken Thompson**

Some time for discussion with this morning's keynote speaker. Session is webcast.

**S084 Peer Workforce**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 02**

**Paper 20 min: Peering into the Canadian Experience**

**Louise Howe**

Australia and Canada have many similarities both in age, size, governance and sporting aspirations. With both countries having an indigenous and diverse cultural population we face some of the same challenges. How do these similarities affect the way we respond to mental health and mental illness? The Mental Health Commission Canada has just realised 'Guidelines for the Practice and Training of Peer Support' off the back of 'Making a Case for Peer Support'. The Guidelines are intended to encourage the development of more peer support capacity and strengthen existing peer support initiatives. Canada already has a peer worker accreditation and certification process. Australia has recently launched a National Framework for Recovery Orientated Mental Health Services and is on the cusp of developing a national framework for peer support. What can we learn from the 'Canadian experience'? Louise Howe travelled to Halifax, Nova Scotia to find out at their first National Conference on Peer Support in May 2014. Louise, paired with 'Peer Work in Middle Earth', presented 'Peering Down Under', a snapshot of the Australian peer work landscape. Louise will share the learnings and laughter from a conference where the theme was hope, empowerment, recovery, promoting growth and accessibility of peer support. **Learning objectives:** 1. People will gain an understanding of how Canada is progressing with making with making peer support a priority. 2. Australia has recently completed a peer work force study that will inform a national strategic framework, complementing the shift to recovery orientated services.

**S084 Peer Workforce**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 02**

**Paper 20 min: Bringing lived experience into focus: Peer Workers in the MDT**

**Lyndal Sherwin Sam Higgins Francesca Coniglio**

The value of the Peer Worker role and the impact of lived experience in the development, delivery and evaluation of mental health services is widely published. The Fourth National Mental Health Plan (2009) outlines actions directly relevant to peer workforce development including increasing the peer workforce in clinical and community settings. The introduction and development of the peer workforce across NSW has seen the commencement of a

significant shift in recovery oriented service delivery. However, challenges remain in this workforce being stretched due to demand, separate from clinical teams and peer workers themselves identifying their roles as tokenistic in nature at times. The Specialist Rehabilitation Service (SRS) within Mental Health Drug & Alcohol, Northern Sydney LHD, have introduced the Peer Worker role within the context of a multi-disciplinary team. The role includes active involvement in the development, delivery and evaluation of the service, working alongside and within the clinical team. The role includes contributing to the delivery of training and supervision and is highly valued along with all other disciplines within the team. The aim of this paper is to present the process of how this position was established and embedded into the service structure of the SRS. It will also explore the impact on the SRS as a whole, service delivery and the way in which this informs future directions.

**Learning Objectives:** 1. The audience will gain information about a successful process in embedding the Peer Worker role within a multi-disciplinary team which supports the value of lived experience in all aspects of service development and delivery, strengthening the ability for recovery oriented service provision. 2. This topic is highly relevant for mental health services seeking to recognise and strengthen the peer workforce, utilising these roles in an effective and meaningful way, and to take the necessary steps towards service transformation to that of true recovery orientation.

**References:** 1. NSW Consumer Advisory Group (2010). Consumer Workers' Forum Project. 2. Literature Review on the Mental Health Consumer Workforce. Sydney: Author. 3. Repper, J. & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20(4), 392-411.

#### **S084 Peer Workforce**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 02**

**Paper 20 min: Building foundations that don't shake - support for the casual Lived experience Workforce**

**Wanda Bennetts**

The lived experience workforce is increasingly being recognised as complementary and integral to the clinical workforce. However they have not to date had any substantial structures and supports on the same level that other disciplines take for granted. They are also generally compelled to undertake their work in the clinical context that can often overshadow and disempower the contribution and messages they have to give. With the growing success of work by casual lived experience workers at the Northern Area Mental Health Service in Melbourne, the organisation has increasingly become interested in continually and robustly developing the right culture, approaches and supports for supporting the growing number of casual employees in this context. This paper will highlight the development and continually evolving foundations and supports that are in place, including a specific casual lived experience workforce committee and supervision and other supports being trialled for this group of employees.

**Learning Objectives:** 1. That participants will reflect on how to build strong foundations to truly embed the casual lived experience workforce ideals into clinical settings. 2. That participants will take away some practical examples of how to support the lived experience workforce.

**References:** Watson, Sandy, (October, 2013), Peer Workforce Development, Centre of Excellence in Peer Support - Conference Keynote Presentation. Bennetts, W., Pinches, A., Paluch., T. and Fossey E. Real Lives, Real Jobs: Sustaining Consumer Perspectives Work in the Mental Health Sector, *Advances in Mental Health* (2013) 11 (3), 313-326.

#### **S085 Community Living**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 03**

**Paper 20 min: Partners In Recovery - together we will assist the homeless****Judith Hopwood**

In many ways homelessness and mental illness are synonymous with more than a third of those falling into homelessness having a mental illness and another third developing a mental illness whilst experiencing homelessness. There have been many policies and projects undertaken over time to address the massive issues faced when homeless with mental ill health but for a significant number there has been little success. The new project titled Partners In Recovery (PIR) is seeking to strengthen the approach to working with homeless people to end homelessness and to do this will form partnerships with key people and organisations. In the Northern Sydney Local Health District the Northern Sydney Medicare Local has commenced a project utilising Partners In Recovery in order to better assist homeless people in the Hornsby Shire. Many live in bushland or in caves and despite some access to services from charities and health authorities, they have immense difficulties accessing housing as well as other means to address mental and physical health challenges. The homeless often live on the fringes of society with numerous hardships facing them. They suffer marginalisation and exclusion and stigma. The concept of partnerships to aid recovery illustrates social justice and social inclusion and tells us that 'what we share makes us strong'. **Learning Objectives:** 1. Attendees will take away information about the application of the Partners In Recovery (PIR) model as it seeks to assist local Hornsby Shire homeless people (Northern Sydney Local Health District, NSW) with a mental illness by working in partnership with stakeholders. 2. Attendees will be reminded that more than half of the homeless suffer a mental illness and it will be imperative for all stakeholders to work strongly together in partnership to solve the issues confronting mentally ill and other homeless people. **References:** Johns, G. (2012). Paved with good intentions: The Road Home and irreducible minimum of homelessness in Australia. Agenda, Volume 19, Number 1. Bureau of Health Information. (2013). Patient perspectives: mental health services in NSW public facilities, Volume 2, Community Mental Health, February 2010 and February 2011.

**S085 Community Living****29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 03****Paper 20 min: Promising practice: The outcomes achieved for participants in the first three years of the Doorway Housing First private rental project for homeless people with mental illness****Tracey Swadling Laura Collister**

Mental Illness Fellowship Victoria implemented the three year Doorway private rental demonstration project for homeless people with a mental illness, utilising a localised version of the Housing First model, in 2010. Doorway's enhancements to Housing First include utilising private rentals; establishing personalised integrated teams comprising clinicians, Doorway workers, the participant and other formal and informal supports, a Peer workforce, as well as specialist employment assistance and development of natural support networks. The purpose of the presentation is to share the knowledge gained in the three years of the Doorway project and the results of an independent evaluation. The domains measured in the summative and formative evaluations were: Housing tenure, Economic participation, Social relationships and community connectedness, Family engagement, Health and mental health, including utilisation of bed-based services. Program model, Program management, Program governance, Program partnerships. This presentation will describe the practical interventions utilised in the Doorway project and the resulting outcomes for program participants, their families, the community and for the organisations involved in the project. **Learning Objectives:** 1. Participants will learn about the practices utilised in the

Doorway project to achieve a range of outcomes for people with mental illness including housing and social inclusion. 2.This presentation is relevant to mental health services because it examines effective service implementation coordinated with clinical mental health and other services that result in improved outcomes for people with mental illness.

**References:** 1.Rosenheck R, Morrissey J, Lam J, Calloway M, Stolar M, Johnsen M, Randolph F, Blasinsky M and Goldman H (2001), Service Delivery and Community: Social Capital, Service Systems Integration, and Outcomes Among Homeless Persons with Severe Mental Illness, Health Services Research, no. 36, pp. 505-512 2.Weistein LC., LaNoue MD, Plumb JD, King H, Stein B, Tsemberis S. (2013), A Primary Care-Public Health Partnership Addressing Homelessness, Serious Mental Illness, and Health Disparities, Journal of the American Board of Family Medicine, vol 26, no 3, pp. 279-287

### **S085 Community Living**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 03**

**Paper 20 min: KidzSpace – The effectiveness of an inter-disciplinary community based paediatric service specialising in child health, safety, development and wellbeing.**

**Sue McConnachie Gail Clarke Andy Lovett Katherine Hyde Andie West**

An innovative paediatric model, kidzSpace, developed by Bendigo Community Health Services(BCHS) to meet the needs of children and families, experiencing vulnerability, risk and complex needs. The team captures the mental, emotional, developmental and physical health needs of children and families. Team members co-consult and commit to providing a treatment plan with family agreement, this often includes a balance of specialist and generalist programs internal and external to BCHS. With over 400 referrals annually, service demand continues to grow exponentially. Increasing clinical education and specialist placements across wide ranging professions strengthens the sustainability of the interdisciplinary approach. The kidzSpace team includes paediatricians, general practitioners, educators, allied health professionals, child legal practitioners, play therapists, child health advocates and mental health specialists. It is proving to be an appealing practice model for health professionals who recognise the importance of child mental health and wellbeing, especially for children experiencing vulnerability or heightened risks that impact on family capacity and wellbeing. This in mind, kidzSpace creates the opportunity for child and family to access interventions, build resilience and enhance ?whole of family? health and wellbeing. It is clear that paediatric interventions are more successful when they are family inclusive (Marans, 2004), ??as outlined in the American Academy of Paediatrics (AAP) Task Force on Family, which ??extends the responsibilities of the paediatrician to include screening, assessment, and referral of parents for physical, emotional, or social problems or health risk behaviours that can adversely affect the health and emotional or social well-being of their child. (Committee on Hospital Care and Institute for Patient and Family Centred Care, p.395:2012). KidzSpace demonstrates integrated responses being effective and promoting the building blocks for ongoing mental, emotional and developmental health. **Learning Objectives:** 1.To learn of the positive outcomes of an inter disciplinary, holistic practice model developed and delivered in a community health setting for children and families who often are identified as vulnerable and at risk of enduring health and wellbeing issues. 2.To learn of the experiences of a wide range of disciplines, encompassing specialist paediatric health, general health, mental health, allied health, and education, working effectively together in an enhanced inter disciplinary paediatric intervention model for children and families. **References:** Marans S. Psychoanalytic Responses to Violent Trauma: The Child Development-Community Policing

Partnership. In: Sklarew B, Twemlow SW, Wilkinson SM, editors. Analysts in the trenches: Streets, schools, war zones. Mahwah, NJ, US: Analytic Press; 2004. pp. 211?236.

### **S085 Community Living**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 03**

**Paper 20 min: An overview of the One Life Suicide Prevention Strategy: a partnership between government and communities in regional and metropolitan areas of Western Australia.**

**Clive Elliot Sandra Burns**

Despite an historical evolution of primary prevention models as suicide prevention strategies, a debate continues regarding their effectiveness compared to secondary and tertiary models. In particular, whether raising suicide prevention awareness within the whole population, who may be 'asymptomatic' of risk, is less effective than selective intervention in its current management and interpretation. Early indications from research conducted under the auspices of the Western Australian Suicide Prevention Strategy (2009-2013), may significantly update the frameworks through which primary prevention is currently understood and delivered. This presentation will discuss the potential to deliver primary prevention effectively by examining the definition and major concepts of prevention, and identifying frameworks for conceptualising primary prevention using both national and international strategies. It will be argued that delivering a suicide prevention strategy to a significant sub-group of the population in the workplace, as critical stakeholders, affords an effective and modernised version of primary prevention. This presentation will discuss the research and experiential findings of this unique partnership, advancing suicide prevention awareness within a cohesive framework connecting communities and workplaces in Western Australia. The presentation will also discuss the challenges and successes of the first two years of the One Life Suicide Prevention Strategy.

### **S086 Workshop: Relaxation; Workshop: Multicultural Mental Health**

**29/8/2014 From: 1030 To: 1230 Venue: Riverview Room 4**

**Workshop 1hr: Development, rationale and use of Rapid Reflexive Relaxation (R3) method. Or How to relearn and love your S Spot.**

**Steve Baily**

This enjoyable workshop teaches participants how to use, then teach an innovative new system, Rapid Reflexive Relaxation ( R3), to rapidly achieve relaxation based on the use of the Suckle Reflex. It results in rapid relaxation, decreased pulse rate, slowed breathing and calming of thought processes starting within seconds. It is essential to bring your sense of humour and willingness to explore. Clinically it enables rapid stopping of panic attacks, disruption of ruminations, reduces insomnia, controls anxiety and reduces auditory hallucinations. The method can be taught in minutes, is undetectable by others and can be practiced while engaging in other activities thus making it an ideal brief intervention for use by busy GPs and other clinicians. While appropriate explanation enhances the effect, it works without needing to know why, making it ideal in emergency situations. An additional fun distress disruption technique Raspberry Quintuplets will also be taught. Recent developments in this technique will be explained including place for use in trauma informed care. Handout of techniques will be provided. Key words : Anxiety, Relaxation, Brief intervention. **Learning objectives:** 1. Participants will learn and learn how to teach two novel powerful rapid acting relaxation and pattern disruption techniques based on early childhood behaviour and reflexes. Participants will also learn the underlying rationale and

physiology to enable explanation to others. 2. This workshop enables people to control their anxiety, panic and frustration in a wide range of situations in a very rapid manner relying on reflexes present in all people. This can also be used in the family and couple context.

**S086 Workshop: Relaxation; Workshop: Multicultural Mental Health**

**29/8/2014 From: 1030 To: 1230 Venue: Riverview Room 4**

**Workshop 1hr: Implementation of the new Framework for Mental Health in Multicultural Australia**

**Rita Prasad-Ildes Hamza Vayani**

This workshop will take participants through the components of the new Framework for Mental Health in Multicultural Australia via a practical demonstration of the online components and discuss its applicability to mental health service organisations. The Framework consists of web based resource and planning tools to support mental health organisations in the public, private and community sectors to improve service delivery to CALD consumers and carers to ensure equitable outcomes in access and quality of treatment and care. Applicable to small or large multi-site services this framework covers all aspects of the organisation including planning, management, service delivery and outcomes monitoring and evaluation. The online package consists of practical tools to assist mental health service organisations and its workforce to improve cultural responsiveness and has been developed to support local quality and safety management processes and practices. Quality management is about continuously improving, making services/organisations more culturally responsive and able to respond to the changing population demographics in their local catchment areas. A key message is that it is not a one-off process but a steady and continuous approach to implementing quality and safety that will result in meaningful change. It should become a fundamental part of the way the organisation operates, rather than a source of additional work. Improving the cultural responsiveness of mental health services will not only result in safer and better quality services but also achieve efficiencies and greater consumer satisfaction. Key components of the Framework include: 'Organisational Cultural Responsiveness Assessment Scale (OCRAS). An organisational self assessment tool comprising eight cultural competency standards which provide scores for each standard enabling organisation to track progress over time. Following the completion of the OCRAS organisations will be able to develop a customised action plan based on priority areas highlighted by the self assessment tool. 'Outcome indicators and strategies for organisations and workers at three levels: beginning, developing and advanced enabling organisations and workers to tailor strategies to their particular needs. Where available, best practice examples around the country are highlighted enabling organisations to connect with others undertaking similar work. Outcome indicators and strategies are also referenced to the National Standards for Mental Health Services (2010) and the National Safety and Quality Health Service Standards (2012) assisting accreditation requirements. 'Supporting evidence and information in the form of key concept sheets about concepts and theoretical underpinning the framework and links to the knowledge exchange centre on the MHiMA Website This workshop will enable participants to become familiar with the Framework and will focus on a facilitated discussion about implementation barriers and opportunities. **Learning Objectives:** 1. Participants will gain knowledge and understanding about the various components of the Framework for Mental Health in Multicultural Australia. 2. Participants will gain knowledge and understanding of the relevance of the Framework to their local service context and strategies for implementation. **References:** Minas H et al, Mental Health Research and Evaluation in Multicultural Australia: Developing a Culture of Inclusion, National Mental

Health Commission, 2013 Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery, Mental Health in Multicultural Australia, 2014

### **S087 Culturally Diverse Communities**

**29/8/2014 From: 1030 To: 1230 Venue: Riverview Room 5**

**Paper 20 min: Community Carer Support Program – Experience of Chinese Carers Looking After Relatives With Dementia**

**Lisa Wong Jane Stein-Parbury Lynnette Chenoweth**

Introduction: Due to cultural barriers, CALD caregivers of people with dementia experience difficulties in their care-giving role and access to services(1). Carer support is important in maintaining the home-based care for people with dementia Aim: To provide support to Chinese carers for people with dementia and to describe their experience in the carer support program. Method: Two 8-weekly carer support programs which were part of the Community Carer Coaching Project(2) were conducted. Data was collected during the group sessions. NVivo and thematic analysis were used to analyse the data. Results: Two male and 17 female Chinese carers participated in two support groups (n=19). Sixty percent of carers were the spouse and 40% were the children. Six themes emerged from the analysis which included: 'sharing of information and helping each other', 'eagerness to seek help', 'carers looking after their own health', 'acceptance and confidence in the caring task', 'developing person-centred caring skills' and 'positive thinking and psychological empowerment'. **Learning Objectives:** 1.After attending this presentation, people in the audience will gain knowledge in dementia, knowing that dementia prevalence is set to soar from an estimated 332,000 people in 2014 to approximately 1,130,000 in 2050 with an estimated 1,130,000 carers' lives being affected. There are more than 1,700 new cases of dementia in Australia each week; approximately one person in every 6 minutes. The audience attending this presentation will come to understand that due to cultural barriers, caregivers of people with dementia who are from culturally and linguistically diverse (CALD) backgrounds experience many difficulties, both in their care giving role and in their access to services. The audience will gain a better understanding of the lived experience of carers for dementia, as well as the importance of supporting these carers to maintain the home-based care for people with dementia and minimize institutional care. 2.Dementia is the third leading cause of death in Australia and there is no cure. Dementia is now a national priority and almost half (44%) of people living with dementia also have a diagnosis of a mental illness. With increasing number of people living with dementia, mental health services will receive increasing number of referrals for assessment, treatment and management of dementia. Carers for people living with dementia are important in maintaining the home-based care in the community, however, the psychological morbidity of these carers are very high. Comparing to mainstream Australian carers, CALD carers had more shame and guilt, more caregiving burden, higher depression scores and higher level of anxiety. This will further increase the burden of mental health services in a long run. It is important to promote mental health of these carers and to support people living with dementia in the community; otherwise, carers are prone to mental breakdown due to increasing carers' stress. It is foreseeable that people living with dementia and stress of their carers will become a major mental health issue in Australia. Conclusion: Qualitative analysis of this carer support program showed perceived benefits of carers in improving their knowledge and skills in person-centred care, and confidence in the caring task. It is important to support these carers in the community to minimize institutional care. **References:** 1.Brody H & Cumming A (2010) Dementia Services in Australia. International Journal of

Geriatric Psychiatry, vol. 25, pp. 887-895.2.Chenoweth L, Jeon YH, Stein-Parbury J, White D & McNeil G (2012) Community Carer Coaching Project - An Education Program for the Carers of People with Dementia. Sydney: University of Technology Sydney

### **S087 Culturally Diverse Communities**

**29/8/2014 From: 1030 To: 1230 Venue: Riverview Room 5**

**Paper 20 min: Connecting with carers from culturally and linguistically diverse (CALD) backgrounds: an eLearning approach to improving cultural competence of mental health clinicians**

**Lisa Woodland Annemaree Bickerton Dushan Ristevski Suzanna Kirov Janice Nair**

This presentation reports on the development of an interactive multimedia eLearning module. The module aims to increase the knowledge, skills and capacity of mental health professionals to provide culturally appropriate care and effectively address issues of stigma experienced by families. Stigma is a significant barrier for carers of people with mental illness accessing health services, health information and community support. These issues are magnified for carers from culturally and linguistically diverse (CALD) backgrounds, particularly if their English language proficiency is limited, health literacy levels are low and existing services are limited in their understanding and response to their needs. The eLearning module presents a conceptual framework for mental health professionals to address these issues. The cultural and linguistic dimension of the 'Pyramid of Family Care' is explored through scenario based learning. The scenario is drawn from Fear and Shame, an award winning Macedonian-language play which creatively explores mental illness and stigma. The play highlights the challenges encountered by the family as they seek help for their youngest son and face the negative reactions of their friends and neighbours. The scenario poses a series of twelve tasks focussing on specific issues in connecting with carers from CALD backgrounds in achieving an effective partnership and addressing stigma. **Learning Objectives:** 1.Participants will learn about the cultural and linguistic dimension of the Pyramid of Family Care and practical strategies to meet the needs of carers from CALD backgrounds.2.A fundamental challenge for mental health services is ensuring staff are equipped to deliver culturally competent care. This eLearning module offers a highly accessible and interactive way for clinicians to enhance their knowledge, skills and confidence in addressing the needs of carers from CALD backgrounds. **References:** Blignault I, Smith S, Woodland L, Ponzio V, Ristevski D & Kirov S. Fear and Shame: Using theatre to destigmatise mental illness in an Australian Macedonian community. Health Promotion Journal of Australia, 2010, 21, 120-126. Mottaghypour Y, Bickerton A. The pyramid of family care: A framework for family involvement with adult mental health services. Aust N ZJ Psychiatry 2000; 34: A47-A47.

### **S088 Educating Students**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 06**

**Paper 20 min: Improving the university experience for students who self identify as having a mental health problem**

**Dianne Wynaden**

University student demographic data highlights an 'at-risk population' for the onset of mental health problems. The transition to higher education is associated with a range of emotional, social and academic demands that can cause psychological distress. At any one time a substantial number of students may be attempting to complete university studies while

managing problematic symptoms, behaviours, or an emerging, or diagnosed, mental illness. This presentation highlights these students' experiences and the facilitators and barriers that this group of students face in completing their study program. Participants were 1378 students enrolled at a Western Australian university who completed a survey during May 2009. The students provided descriptions of the range of issues that interfered with their lives, and university studies. Not surprisingly, the most commonly identified issues were depression, anxiety, and stress-related concerns. More than half the students surveyed had not sought professional help for their concerns and this highlights that important role that universities need to play in improving the pathways to primary care and early intervention. Universities must foster a supportive environment with a culture that promotes mental wellbeing and works to decrease the stigma associated with mental illness. **Learning Objectives:** 1.Improve the outcomes for university students who have a mental health problem. 2. Decrease stigma within the university environment towards students with mental health problem. **References:** Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behaviour among college students. *Journal of Adolescent Health, 46*, 3-10. Wynaden, D., Wichmann, H., & Murray S. (2013). A synopsis of the mental health concerns of university students: Results of a text-based online survey from one Australian university, *HERDSA, 32:5*, 846-860

### **S088 Educating Students**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 06**

**Paper 20 min: Beyond the rabbit hole of maintenance ... to professionals teaching and living lives of recovery.**

**Jane Gibson Lyn Mahboub**

No one comes to work in mental health for the money! Indeed, most practitioners will attest that their express reason for working in this space is to support the people they work with to recover. However, with all the hype about this thing called 'recovery', the multiple, but different, definitions and training packages, one could understandably feel confused. This paper seeks to drill down to discuss personal recovery as distinct from clinical and social recovery and, in particular, highlight the trap of maintenance-style practice and unpack 'recovery practice'. Real examples of practice from three divergent but complimentary perspectives will be shared, reflecting on what it takes to move beyond maintenance toward gratifying, heart-warming practice that is fulfilling and ignites the flame that drew us to this work in the first place. This will create the space for delegates to reflect on their own practice change, and create greater connection and authenticity around recovery. **Learning objectives:** 1. Personal recovery as divergent from clinical and social recovery (rehabilitation) oThe elements of recovery and maintenance and how they differ oAccounts of what it took for three professionals to shift practice to connect with recovery values and lived experience such that audience members may consider doing so in their own practice. 2. This paper explores practical ways to take the oftentimes confusing rhetoric around recovery into practice reality and will thus be of great relevance and interest to mental health practitioners working in mental health services or community managed organisations. In true style of what we share make us stronger, this presentation will demonstrate deep collegial relationships that bring together our collective experience of multiple and intersecting identities and lived experiences that are relevant to the mental health sector. These include that of student, teacher, occupational therapist, senior recovery trainer, nurse, recovery advisor, consumer academic, critical psychologist and psychotherapist. **References:** 1. Holttum, S. (2012). Research watch: Recovery as a personal journey: How mental health services are trying to support it. *Mental Health and Social Inclusion, 16(4)*, 169-174 2. Slade, M., Amering, M., Farkas, M., Hamilton, B., O'

Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1), 12-20.

### **S088 Educating Students**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 06**

**Paper 20 min: "I feel much less scared": Students learning from lived experience of mental health recovery.**

**Robyn Martin Sophie Ridley Lyn Mahboub**

Consumer and family participation and involvement are hallmarks of Australian mental health policy, frameworks and standards (Australian Government 2010; Australian Health Ministers' Advisory Council 2013). The specific roles consumers enact in the education of mental health professionals courses varies from limited to extensive contact and may involve guest lectures where consumers share their recovery story through to contracted academic roles such as unit coordination (Happell et al. 2014). Regardless of the type of input or role, meaningful involvement of people with lived experience in the tertiary education of allied health, nursing and medical students promotes deeper understanding and greater empathy. This paper reports on the partnership formed between two academics (one defined as a consumer academic) in establishing and sustaining a role where lived experience is valued and privileged in coursework units for undergraduate and postgraduate students. In addition, the findings from two research projects on the consumer academic's impact on student knowledge, skills and values will be reported. **Learning**

**Objectives:** 1.The audience will learn about: - The processes involved in creating the conditions for meaningful consumer participation in the education of undergraduate and postgraduate mental health students. -Findings from two research projects which examined the impact of the Consumer Academic's contributions to social work students' learning and practice. -Ways in create partnerships with consumers in tertiary settings can be created and sustained. 2.Given the policy emphasis on the meaningful involvement of consumers in mental health service delivery, research and policy development, the proposed paper is highly relevant to contemporary mental health practice. This presentation provides a grounded example, supported by research evidence on ways to create the conditions for meaningful contributions from mental health consumers in the tertiary education setting.

**References:** Australian Government. (2010). National standards for mental health services. Canberra: ACT: Australian Government. Retrieved from [www.health.gov.au](http://www.health.gov.au) Australian Health Ministers' Advisory Council. (2013). A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Canberra: Australian Government. Happell, B., Byrne, L., McAllister, M., Lampshire, D., Roper, C., Gaskin, C., et al. (2014). Consumer involvement in the tertiary-level education of mental health professionals: A systematic review. *International Journal of Mental Health Nursing*, 23, 3-16. doi:10.1111/inm.12021

### **S089 NDIS; Community Living**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 07**

**Paper 20 min: Community Living - Key lessons from the Community Independent Living Strategy (ICLS) at Ruah.**

**Meagan Shand Steve Joyce**

Methodology: Action Research methods (Crane & O'Regan, 2010) were used to follow the implementation of the project and integration of individualised ways of working into service delivery. Most Significant Change techniques (Dart & Davies, 2005) were applied to gather personal stories of individuals who participated in the strategy. Findings: Delegates will learn key achievements and changes made to service delivery to strengthen individualised ways of working (Department of Premier and Cabinet, 2011), including and not limited to: partnerships, organisational systems, planning and assessment, staffing and budgets, and measuring outcomes to meet the six WA Mental Health Commission outcomes statements (Wilson, Jenkin & Campaign, 2011).. The value of the research methods used will also be discussed, as well as the obstacles and challenges along way. Conclusion: This presentation combines scientific methods with the voice of experience to add to practice based evidence for supporting community living outcomes for people who live with mental illness, their families and significant others. **References:** Crane, P. and O'Regan, M. (2010). On PAR - Using Participatory Action Research to Improve Early Intervention. Dart, J.J. and Davies, R.J. (2005). The Most Significant Change (MSC) Technique. Department of Premier and Cabinet. (2011). My Life My Way - Self Directed Supports in Western Australia. Perth: Government of Western Australia. Wilson, E.; Jenkin, E. & Campaign, R. (2011). Outcome Measurement of Community Based Mental Health Services in Western Australia: Literature and Concept Summary. Melbourne: Inclusion Matters.

### **S089 NDIS; Community Living**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 07**

**Paper 20 min: Further Unraveling Psychosocial Disability: The Lived Experience of the National Disability Insurance Scheme from the First Year at the NSW Hunter Launch Site**

**Tina Smith**

The purpose of this paper is to describe work undertaken during the first 12 months at the NSW Hunter National Disability Insurance Scheme (NDIS) launch site to maximise opportunities presenting to better assist people with high levels of psychosocial disability secondary to mental ill health. It is aimed that this foundational activity will contribute to client outcomes, thought leadership and also inform research and development directions regarding the inclusion of people affected by mental health issues through the NDIS both in NSW and nationally. The Hunter is unique in the level of Year 1 mental health and NDIS activity undertaken and including that it is the only Year 1 adult launch site that also has a 'Partners in Recovery' (PIR) initiative. It is not yet well understood how the emerging NDIS and existing mental health services will best work together to support all people affected by mental illness including those not eligible for tier 3 funded support packages - to lead valued and contributing lives through increasingly personalised funding and 'choice and control' options. Existing mental health services include public providers providing primarily acute/subacute treatment interventions, primary healthcare providers and also non-government community managed organisations (NGOs/CMOs) providing a range of Commonwealth and State funded psychosocial rehabilitation and recovery support mental health programs. **Learning Objectives:** 1.Conference delegates attending this session can expect to leave more informed about opportunities and challenges presenting through the NDIS implementation journey from a mental health sector and psychosocial disability perspective. 2.This topic is relevant to the mental health sector in that at full roll-out the NDIS is expected to deliver services to 57 thousand Australians with high levels of psychosocial disability secondary to mental ill health. **References:**Smith T. Further Unraveling Psychosocial Disability: Experiences from the NSW Hunter Disability Insurance Scheme Launch Site . In New Paradigm (VICSERV: Summer 2014 - National Disability

Insurance Scheme). National Mental Health Consumer and Carer Forum (NMHCCF: 2011), Unraveling Psychosocial Disability: A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions. Canberra: NMHCCF.

### **S089 NDIS; Community Living**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 07**

**Paper 20 min: Preparing for the NDIS: Learnings From a Pilot Project Trialing Client Directed Funding Packages**

**Kyalie Tapper Laura Collister**

With the move towards the impending NDIS, three PDRS Service Providers (Mental Illness Fellowship, Doutta Galla Community Health Services and Merri Community Health Services) joined a consortium to trial a program simulating the NDIS principles to prepare for these changes. The Purpose of this presentation is to share the learnings from this pilot project called Choices: Building a Good Life, trialing client directed funding packages. A review of the evaluation of the project conducted by Social Ventures Australia will be shared, where recipients will hear about system challenges that moving to personalised services bring, identified infrastructure necessary to support the new system, what services clients want, how to support clients to exercise choice and control, and whether personalised, client directed funding leads to improved life circumstances for people living with a mental illness and at what cost. **Learning Objectives:** 1. Recipients will gain an understanding of some of the potential challenges and risks Mental Health organisation along with participants will face operating within the NDIS framework as well as opportunities to be gained. They will also learn about what kind of services and products clients are choosing and what outcomes were gained for participants accessing the project. 2. This presentation is relevant to mental health services because it reviews outcomes specifically related to the NDIS, mental health service delivery and needs of people accessing mental health services. **References:** Duffy S, Williams R, (2012) The Road to NDIS: Lessons from England about Assessment and Planning. Australia, JFA Purple Orange Scown S, Sanderson H, (2010) Making it personal: a Providers journey from Tradition To Transformation. Dimensions and HAS Press.

### **S089 NDIS; Community Living**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 07**

**Paper 20 min: Talking to people with psychosocial disability: how to facilitate discussion about their preferences for treatment, support and care in the context of the National Disability Insurance Scheme.**

**Lisa Brophy Annie Bruxner Erin Wilson Michael Stylianou Nadine Cocks**

This presentation aims to follow the recovery focused research principles (Slade, 2009; Davidson, Shaw et al., 2010) that guided the project. It emphasises that people with mental ill health are experts through lived experience and that community engagement and participatory research methods are essential to facilitating the voice of the consumer. The research explored aspects of what makes life meaningful (a good life) for people with psychosocial (Rhodes, 2012). There is an increased interest in providing people with psychosocial disability opportunities to flourish as opposed to the current situation in which many appear to be languishing by comparison to the rest of the community (Keyes & Haidt,

2007; National Mental Health Commission, 2012). The NDIS is linked with this concept (Commonwealth of Australia 2013). These principles and approaches enabled research participants to express their needs and support preferences which may influence the community managed mental health service sector (CMMHSS) in the context of the NDIS. The presentation explores innovative research methods, participants prioritisation of life goals, their means to achieving these goals and the implications for service provision in the CMMHSS. The ability of consumers to articulate their personal preferences to service providers is meaningless unless services enable consumers to have a voice about their values, life goals and aspirations. However, the long established discourse of disability that has emphasised impairment and deficit was anticipated to constrain the ability of some consumers to articulate support needs and preferences consistent with a conceptual framework that emphasises recovery and wellness. As Williams (2011) suggests, changing this discourse requires a cultural change in mental health services (especially as self-directed funding is introduced which enables a shift in power relationships). Therefore, the research went beyond asking people about their needs and used the questions suggested by Rhodes (2012) including: What really matters to you? How do you want to live a good life? These questions enable people to identify what they want rather than what they know services offer. These 'good life' questions encouraged participants to think outside of the square and encouraged discussion about what really matters to them. Questions were also asked about how people might access these needs and how funding, such as that proposed by the NDIS, would assist in achieving these goals. To address the need for cultural change that facilitates informative and meaningful discourse with consumers, participatory research methods were introduced. These included visual prompt cards around 14 life goal areas, and the 10 seeds technique (Jayakaran, 2002). **Learning Objectives:** Presentation attendees will learn new ways of facilitating discussion around the needs and preferences for treatment, care and support of people with psychosocial disability eligible for NDIS. They will also learn how people with psychosocial disability prioritise life goals and support needs. This is relevant to CMMHSSs because assessing needs for support services is not straightforward in this field. Innovative communication strategies and perspectives can contribute significantly to facilitating these discussions and improving service delivery. **References:** Commonwealth of Australia. (2013). 'National Disability Insurance Scheme: what is an NDIS?'. Retrieved from <http://www.ndis.gov.au/about-an-ndis/what-is-an-ndis/>. Accessed 3rd March, 2014. Jayakaran, R. (2002). The ten seed technique. People's Republic of China, World Vision China. Keyes, C. M. L., & Haidt, J. (Eds). (2007). Flourishing: positive psychology and the life well lived. Washington, D.C.: American Psychological Association.

### **S090 Trauma, Stigma**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 08**

**Paper 20 min: A Trauma Informed Royal Commission**

**Cathy Kezelman**

The Royal Commission into Institutional Responses to Child Sexual Abuse has put the issue of child abuse onto the national agenda. Many stories have been told, heard and listened to. The Commission has borne witness. As the public hearings have been streamed live, and reported daily in the media, the Australian public have repeatedly evidenced the lived experience of childhood sexual abuse, violations, brutality and profound neglect. Yet the sharing of stories, although often profoundly challenging has also empowered victims. By all reports the Royal Commission has almost universally worked from trauma informed principles and responded to victims with empathy, respect, validation and understanding. Many victims have come forward, not only for themselves but, so that

they could make a difference to the lives of others. Their collective voice has shone as a beacon of hope and resilience. With a collective voice and shared experience we can achieve a great deal. This presentation acknowledges the strength and resilience which allows us to survive the most profound distress, the benefits of a trauma informed approach in the midst of an inherently re-traumatising environment and the possibility of hope despite it all. **Learning objectives:** 1. Learn about the principles of trauma informed practice - safety, trustworthiness, choice, collaboration and empowerment and their application within current very public environment 2. Focus on a strength-based approach, issues of resilience, and empowerment to provide hope, optimism and possibilities for recovery. **References:** 1 Adults Surviving Child Abuse 2012 Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery Adults Surviving Child Abuse: Authors Kezelman C.A. & Stavropoulos P.A. 2. Guarino, K, Soares, P, Konnath, K, Clervil, R & Bassuk, E 2009, Trauma-Informed Organizational Toolkit, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation, viewed 25 September 2012 <http://www.familyhomelessness.org/media/90.pdf>.

### **S090 Trauma, Stigma**

**29/8/2014 From: 1030 To: 1230 Venue: Meeting Room 08**

**Paper 20 min: Pass the Can Opener: Highlighting barriers to implementing trauma informed care and practice within mental health services**

#### **Indigo Daya**

The high prevalence of trauma amongst people with a lived experience of mental health issues is now well established. Today we also have a greatly improved understanding of how typical responses to trauma can be misinterpreted as, or contribute to, symptoms of mental health issues. In 2012 ASCA (Adults Surviving Child Abuse) released practice guidelines for Trauma Informed Care and Practice (TICP) to aid services in responding to the needs of trauma survivors. Despite all of this knowledge and work, services have been slow to take up the policy change and workforce development necessary to implement effective TICP. A potential effect of this is that the majority of consumers are still not receiving support to disclose trauma histories, or to access supports to recover from traumatic experience. The fear of 'opening the can of worms' remains a very real barrier to recovery. This presentation will highlight the essential changes required for workers and services to become trauma-informed. It will then examine major barriers to becoming trauma-informed, from the perspective of mental health workers who have attended TICP training with the presenter over the past two years, and the presenter's own lived experience as a consumer and trauma survivor. **Learning Objectives:** 1. To appreciate the many barriers which can prevent workers and organisations from implementing trauma-informed care and practice, and explore potential options for minimising these barriers; 2. To build appreciation for the necessity and implications of becoming a trauma-informed practitioner or organisation. **References:** Kezelman, C., & Stavropoulos, P. (2012). Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA). Muskatt, C. (2013). Trauma-informed care in inpatient mental health settings: A review of the literature. International Journal of Mental Health Nursing, 2013, 1-9.

### **S091 Advocacy, Recovery, Research**

**29/8/2014 From: 1030 To: 1230 Venue: Amcom Suite**

**Paper 20 min: Safely using social media for the promotion of mental health advocacy and services**

**Chris Wagner**

Australians are increasingly seeking information about mental health from the Internet. A significant part of this online conversation is occurring within the boundaries of social media. Mental health organisations have an opportunity to promote their work, and their services, through this medium to a broad and highly engaged audience. However, as Australians of all ages are using social media to reach out to friends and to service providers, they can, and do, occasionally present with at risk behaviours or behaviours associated with risk. When they do this, they can encounter stigma, discrimination and under-prepared mental health organisations. What can advocacy bodies and services providers do in such cases? How can we engage safely on social media, and promote our activities and services while also meeting our duty of care? What is our duty of care? This paper will provide practical advice on using social media as a promotional platform, using the World Mental Health Day campaign from 2013 as a case study. In addition the presentation will provide a range of tools to help recognise and respond safely to people who may be experiencing crisis and reaching out through social media. **Learning Objectives:** 1.Participants will take away practical advice on the use of social media to promote their activities and services, as well as tools to assist them to engage safely with people who are displaying mental health issues online. 2.Social media is being used by a significant proportion of Australian mental health sector stakeholders, including service providers and advocacy bodies. Many are highly skilled at the use of this medium, while many are only just discovering and understanding the medium. This paper is aimed at those starting out and those with intermediate skills. **References** Mental Health Begins with me - World Mental Health Day Campaign <http://www.1010.org.au> Swirski, T. Learning the Language of Social Media with Young People. Burns, J.M. et al Game On: Exploring the Impact of Technologies on Young Men's Mental Health and Wellbeing.

**S091 Advocacy, Recovery, Research**

**29/8/2014 From: 1030 To: 1230 Venue: Amcom Suite**

**Paper 20 min: 'Stepping On' with Recovery**

**Mandy Meehan Nadia Williams**

Current evidence suggests that anxiety, depression and multiple medications are big predictors of falls in older people. The goal of this pilot study was to assess the feasibility of a structured evidence based falls prevention program with sub-acute community older Mental Health consumers to prevent falling, build confidence and improve self efficacy. The Stepping On program (Clemson, Swann 2008) was provided to 10 consumers with mixed diagnoses who were identified as high risk fallers. They were enrolled in the single arm pilot trial taking part in the seven week program (two hours a week) A battery of validated instruments was administered at baseline and at week seven. The participants all completed the course. There were no adverse events during the sessions. Outcome measures resulted in 100% improvements in gait strength and balance. K10 measures showed a 27 point improvement for the group. After three months, improvements were independently maintained. We found the Stepping On program safe and easily transferable and cost effective. Recruitment is feasible. Our data suggests Stepping On was beneficial in improving mobility, increasing confidence, improving mood and reducing fear of falling by encouraging desired behavioral changes and promoting responsibility for individual health. **Learning Objectives:** 1.To demonstrate how you can effectively work across Sectors and stakeholders to improve the mental health and well-being for mental health consumers. 2.To demonstrate the effectiveness of an evidence based program that encourages behavioral changes and promotes responsibility for individual health. **References:** Painter JA, Allison L, Dhingra P, Daughtery J, Cogdill K, Trujillo LG. Fear of falling and its

relationship with anxiety, depression, and activity engagement among community-dwelling older adults. *Am J Occup Ther.* (2012) Mar-Apr; 66(2): 169-76  
Clemson L & Swann M. *Stepping On: Building confidence and reducing falls. A community-based program for older people.* (2008) 2nd Ed. Sydney University Press.

**S091 Advocacy, Recovery, Research**

**29/8/2014 From: 1030 To: 1230 Venue: Amcom Suite**

**Paper 20 min: 'You want to do what!' – the story of 17 people, 5 boats and a journey towards wellness – The River 2 Recovery**

**Mark Johnstone Sebastien France Shane Cole Phil Eddy**

River 2 Recovery resulted from a group of Day 2 Day Living participants asking 'how do we do something like that' after a St Luke's Recovery Worker described his own Murray River journey. The project was developed and over two years, in partnership with Wodonga TAFE, a group of 17 participants engaged in Certificate 1, Transition Education; built 5 row boats and rowed 225km over 11 days down a stretch of the Murray River. Participants were involved in various activities, specifically, stakeholder meetings; fundraising; rowing; 'on ground' support and public speaking through a range of mediums. Project funding was provided through NSW Mental Health Programs, sponsorship and fundraising with the journey being launched by Minister Kevin Humphries, officiated by The Hon. Mr Tim Fischer, on 22nd November 2013 culminating on 2nd December 2013. River 2 Recovery is an example of what is possible through innovative approaches to recovery - an inclusive team-focused venture that brought together people living with mental health challenges with a shared purpose not only to achieve personal goals, build the boats and complete a certificate but more broadly to reduce the stigma of mental health by highlighting the strengths and capabilities of those with lived experience. **Learning Objectives:** 1. This presentation will provide the audience with an opportunity to hear about how client directed practice in a group setting provides an energy and enthusiasm that leads to measurable psychosocial outcomes for the individuals involved in the program. The audience will also hear from Sebastien, a participant in the program, how the group developed new relationships with community groups, businesses, local government, media and the broader Albury / Wodonga community. 2. The presenters will demonstrate how this community based project aligns with research evidence linking social inclusion with positive mental health outcomes. There will be a focus on how underlying practice principles driving the project (i.e. self-determination, building resilience, connecting, respect, choice and voice) in conjunction with key partnerships can lead to significant change and provide a foundation for future recovery. **References:** Mental Health Coordinating Council, 2007, Social Inclusion its importance to mental health, publication

**S091 Advocacy, Recovery, Research**

**29/8/2014 From: 1030 To: 1230 Venue: Amcom Suite**

**Paper 20 min: Consumers pushing research translation**

**Anne McKenzie Hayley Haines Lorraine Powell Qun Mai**

Research undertaken at The University of Western Australia School of Population Health (the School) over the past decade has shown that physical health outcomes for mental health consumers lag far behind those of other Australians. The research has highlighted: People with mental illness have an unacceptably high burden of physical health problems with resultant physical disabilities and premature death. With the exception of the small percentage (but unacceptable absolute number) of people with mental illness who do not have a home address, the nature of the problem is not a basic lack of access to primary medical care services from GPs. In fact, most people with mental illnesses see the GP at a

higher than average frequency[1][2][3]. However, there is evidence that the people with mental illness are being failed by a comparatively low level of holistic health care delivered during GP visits. In particular, normal standards of care with respect to proactive management of chronic diseases, such as diabetes and cardiovascular diseases are not being achieved. In line with The University of Western Australia School of Population Health's (the School) commitment to involving consumer and community members in its research programs[4], two community forums were held in 2011 and 2012. The aim of these forums was to discuss the research and provide feedback on ways to address the findings. 36 consumers and stakeholders from government agencies, non-government agencies and consumer groups attended the second forum to workshop three questions to identify a range of solutions that could be developed into recommendations and put to the appropriate decision making bodies. Responses from the forum broadly fell into the following key areas: accessibility to services, relationships between service providers and mental health consumers, education and funding. Recommendations have been developed. **Learning Objectives:** 1. Knowledge about recent research that was conducted at The UWA School of Population Health on the physical health of mental health consumers. An awareness and understanding of a model for consumer and stakeholder contribution to the research process, specifically in the development of recommendations to translate research findings into policy and practice. Knowledge about the successful Consumer and Community Participation Program at The University of Western Australia, School of Population Health and the Telethon Institute for Child Health Research. **References:** [1] Mai Q, Holman CD, Sanfilippo FM, Emery JD, Stewart LM. Do users of mental health services lack access to general practitioner services? *Med J Aust.* 2010 May 3;192(9):501-6. [1] Mai Q, Holman CD, Sanfilippo FM, Emery JD, Preen DB. Mental illness related disparities in diabetes prevalence, quality of care and outcomes: a population-based longitudinal study. *BMC Med.* 2011;9:118. [1] Mai Q, Holman CD, Sanfilippo FM, Emery JD. The impact of mental illness on potentially preventable hospitalisations: a population-based cohort study. *BMC Psychiatry.* 2011;11:163. [1] Involving People in Research. Perth: The University of Western Australia School of Population Health & Telethon Kids Institute; 2011 [cited 2014 13.03.2014];

### **S093 International Collaborative Research**

**29/8/2014 From: 1330 To: 1500 Venue: Riverside Theatre**

**Symposium 1.5hrs: Sharing Mental Health Service research results from Wales, Hong Kong and Australia.**

**Christine Baker Paul Hickey Peter Huxley Sherrill Evans**

The theme of this symposium is mental health services research findings that result from international collaborations between mental health researchers in Wales, Hong Kong and Australia. In particular the symposium looks at social inclusion research in mental health services in each country but also includes internationally relevant workforce research. The results consistently show that there are more commonalities than differences across cultures. Learning objectives: 1. the audience will take away an understanding of the similarities and differences in mental health research contexts and research findings in the three countries. They will learn the nature of social inclusion in multiple cultures, and that cultural differences are not as great as they are sometimes thought to be. They will appreciate best practice in relation to interventions to reduce stress among people caring for dementia sufferers, and where they can access information and the best evidence based intervention programmes. They will be better informed about social interventions. 2. Mental health services internationally are required to demonstrate improved outcomes for service users. Improved social inclusion is important to service users. This symposium will

cover the results of a social inclusion measure applied in different cultures and the obstacles and facilitators to implementation in North Brisbane. Deliberate self-harm is common in all three countries. The audience will take away information from new research into an effective intervention for people who deliberately self-harm for the first time. Staff stress in residential services for people with dementia is an issue internationally. The audience will take away an understanding of the stresses and the means to reduce them.

**Presenter and Chair: Professor Peter Huxley. Presenters: Sherrill Evans, Peter Huxley, Paul Hickey, Chris Baker and A N Other Paper 1: Social inclusion (SCOPE) in mental health services in Hong Kong and Wales:** comparative results:Abstract:According to the World Bank's definition, 'Social Inclusion refers to promoting equal access to opportunities, enabling every member of the society to contribute to social and economic program and share in its rewards.' Review of literature found that there is a lack of empirical and evaluative studies that are dealing directly with social inclusion. A robust measure of social inclusion [Social and Community Opportunities Profile (SCOPE)] has been developed in UK that is multidimensional and captures multiple life domains. A vigorous process was undergone to develop a Chinese version of SCOPE that is relevant to the contexts of Hong Kong society. The process includes a focus group study using concept mapping method; translation and back translation of the items; replacing selected items about local issues with questions from Hong Kong Population Census; and pilot-testing the Chinese version of SCOPE.With the help of non-profit organizations, a non-probability sample survey using the Chinese version of SCOPE was conducted among 170 mental health services users with common mental disorder and severe mental illness in Hong Kong. A sample of 43 mental health services users and 50 Chinese community residents was conducted in UK. The key findings for both surveys will be reported and compared. **References:** Kara Chan, Sherrill Evans, Yu-Leung Ng, Marcus Yu-Lung Chiu, Peter Huxley (2014) .A concept mapping study on social inclusion in Hong Kong. Accepted by Social Indicators Research.Huxley, P, Evans, S. Et al (2012) Final Report to the NIHR HTA.Project Number: 06/91/16: Development of a Social Inclusion Index to Capture Subjective and Objective Life Domains (Phase Two). **Paper 2:Introducing social inclusion outcomes (SCOPE) into community mental health services in South Brisbane.** Abstract: People with mental health problems are one of the most socially excluded groups in society (Social Exclusion Unit, 2004). This presentation has two aims; firstly to describe a proposed research project that measures adult mental health consumers' level of social inclusion, the impact of this on the recovery process and social work practice. Secondly to argue that addressing social inclusion is as a core element of recovery based practice.Social inclusion remains a contested concept yet combined with recovery it is the first of the five priority areas of Australia's Fourth National Mental Health Plan. Despite this there is no agreed outcome measure in use in Australia to measure social inclusion. The research project presented will utilise the Social and Community Opportunities Profile (SCOPE) to facilitate the measurement of both subjective and objective measures of social inclusion allowing a systematic means to identify issues of social inclusion and measure the effectiveness of targeted interventions. In summary social inclusion has been endorsed at a national level, it can be objectively and subjectively measured, it provides a conceptual framework to understand a range of disparate interventions and as Coombs (2013) states 'social inclusion is too important not to measure properly' Coombs et al (2013) p13. **References:** Coombs, T, Nicholas, A and Perkis, J (2013) A review of social inclusion measures, Australian and New Zealand Journal of Psychiatry, 00 (0) 1-14.Social Exclusion Unit (2004) Mental health and social exclusion. Social Exclusion Unit Report. London: Office of the Deputy Prime Minister. **Paper 3: Research into the mental health service workforce:** staff stress in dementia care homes

in Wales: An intervention study .Abstract:Staff working in care facilities are of vital importance to the quality of care and quality of life of people with living with dementia, and the relationship between the resident and caregiver is a central feature of this quality. However, caring for people with dementia can be stressful and demanding for staff. Resident behaviours (e.g. using inappropriate language, agitation, aggression, wandering etc) can contribute to strain. Staff become emotionally exhausted and work-stress may also contribute to high staff turnover rates. Without support, staff can become less willing to care, develop pessimistic and negative emotional responses. There may also be emotional costs to work colleagues and economic costs to the provider due to sickness and absence. The study aims to identify an evidenced based intervention for reducing stress in the dementia care workforce in care homes in Wales, and will test these out in care facilities. This presentation will focus on a survey conducted as part of the study that aims to investigate dementia-related attitudes of the staff working in a variety of care homes as well as the extent of work stress and satisfaction levels prior to the intervention. Very little research has investigated the pressures placed on long-term care workers. (201).

**References:** Zimmerman S, Williams CS, Reed, PS et al. Attitudes, stress and satisfaction of staff who care for residents with dementia. *The Gerontologist*, 2005. 45: p. 96-105. Wolever RQ, Bobinet KJ, McCabe K, Mackenzie ER, et al. Effective and viable mind-body stress reduction in the workplace: a randomized controlled trial. *J Occup Health Psychol*. 2012 Apr;17(2):246-58. doi: 10.1037/a0027278.

**Paper 4: Social work intervention following self-harm in Wales (SWISH):** A replication of intervention research in Melbourne :Abstract.A successful social work intervention for people with a first episode of self harm behavior and no current or previous psychiatric history was undertaken in Melbourne by Joubert and colleagues. People were randomly allocated to treatment as usual or a package of care including brief psychotherapy and assertive outreach. The intervention resulted in a significant reduction in hospital readmissions for self harm and quality of life improvements. Using the same design and measures in Glan Gwili and Prince Philip hospitals in Carmarthen, the replication will see if the intervention is feasible in Wales and if similar outcomes can be achieved. This paper will report on the progress of the SWISH project to date. If the project is successful then funding for a full clinical trial will be sought. **References:** Joubert L, Patrakis M, Cementon E. Suicide attempt presentations at the emergency department: outcomes from a pilot study examining precipitating factors in deliberate self-harm and issues in primary care physician management. *Social Work Health Care* 2012; 51(1)66-76. Petrakis M, Joubert L. Suicide prevention through a social work model of assertive brief psychotherapy and community linkage: use of the Manchester Short Assessment of Quality of Life (MANSA). Project report : Monash University and the University of Melbourne Australia, 2012.

#### **S094 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 01**

**Snapshots - Brief Paper 10 min: 'WellSpring' art therapy group: promoting personal and social wellbeing for older people**

**Vicki Mau Michelle Krieg**

Art therapy groups are a valuable means by which mental health services can maintain a whole person, strengths based recovery approach. Older people living in the community with symptoms of mental illness are more susceptible to social isolation due to a number of factors, including grief, ill health, and financial instability (SANE Australia, 2013). Such individuals have a wealth of wisdom and life experience to share, but may lack the confidence or means to do so. Art based practices have been found to play a substantial role in mental health recovery, particularly in the areas of self-discovery, self expression,

relationships and social identity (Van Lith, Schofield & Fenner, 2013). Art therapy in a group context provides an opportunity for referred older people (65+ yo) to participate in art based activities which promote creativity, reminiscence and expression of emotions and ideas. Various creative and multisensory modalities, such as collage, painting, music, clay and weaving were used to facilitate self-reflection and explore aspects of wholehearted living. Towards the conclusion of the series, there was an intentional exploration and introduction to other avenues in which participants could share their strengths and remain connected to the community. Participants reported that 'Wellspring' art therapy group provided a valuable forum for sharing life experiences with others, to 'branch out, take a risk and have a go' and to build 'courage to go forward'. **Learning Objectives:** 1. An example of how participation in an art therapy group for older people can promote a renewed sense of creativity, personal growth and social wellbeing. **References:** SANE Australia 2013. Growing older, staying well: mental health care for older Australians: A SANE Report. SANE Australia Van Lith T, Schofield M J, Fenner P. Identifying the evidence-base for art-based practices and their potential benefit for mental health recovery: A critical review. *Disability & Rehabilitation*, 2013; 35(16):1309-1323

### **S094 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 01**

**Snapshots - Brief Paper 10 min: Healing Agoraphobia: It's Not About Fear of Open Spaces.**

**Sonia Neale**

Agoraphobia is caused by long-term unresolved chronic stress resulting in a fixed and rigid belief system. Socrates is alleged to have said; 'the examined life is not worth living,' and he was right. Until the belief system of people who cannot leave their houses is examined by a caring, curious other, there is no life worth living. The Uniting Care West (UCW) Personal Helpers and Mentors programme employs caring, curious others to help their participants discover the Socratic good life through discovering their skills and talents and establishing goals. Measuring the progress of people with agoraphobia is very incremental. If living dangerously means adding sultanas to their porridge because they have always eaten it plain then crossing the threshold out the door for a walk in the park can be perceived as a life threatening situation. UCW is a not-for-profit, community services agency in Western Australia. As a Peer Support Worker I spent 16 months working with a man suffering from agoraphobia, whose ingrained belief system also involved thinking he would be murdered if he left the house and walked around the block. He is now a volunteer gardener well respected by his team. Relationship with caring others is everything. **Learning Objectives:** That establishing trust and rapport with patience, insight and wisdom is crucial to achieving success, not only in the UCW PHAMS programme, but in any mental health programme. PHAMS is based on a mentoring relationship where the mental health worker is curious about the strengths, skills, talents and goals of the participant. That the worker is there to be a friend and show wonder, excitement and curiosity about where the participant's life will lead. That with consistency and reliability, kindness, curiosity, humour, gentle challenging and examining and unpicking tightly held rigid core beliefs can slowly make a person believe in themselves enough to want to be open to new experiences. And when that happens it changes the worker as well as the participant. It is a mutually transformative relationship. It has been said that the relationship heals more than the mode or type of therapy or programme involved. PHAMS is a relationship based programme where two people connect to discuss the meaning of the life of the participant. Genuine authentic relationship is the key to good mental health for everyone regardless of

whether they have a mental illness or not. Without honest, caring relationships people feel isolated, alone, withdrawn from society and can become dangerously ill in the process. Even when you have entrenched, severe mental illness, a good relationship can slowly break down the internal barriers that prevent participation in a good life. **References:** Why Love Matters - How Affection Shapes a Baby's Brain - Sue Gerhardt A General Theory of Love - Lewis, Amini, Lannon

#### **S094 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 01**

**Snapshots - Brief Paper 10 min: Do our processes assist people to recover?**

**Janet Ford Robert Heffernan**

RichmondPRA resourced, planned, implemented and reviewed an internal appraisal of recovery oriented practice in five RichmondPRA pilot sites. The purpose of this appraisal was to capture a snapshot of the recovery oriented practices currently utilised by teams in a variety of settings. The sites included a residential service, two community based services (one in a metropolitan area and one in a regional area, a day to day living centre and an employment service. The Recovery Oriented Service Self-Assessment Tool (MHCC 2011), consisting of six domains, was utilised to reveal evidence and gaps of recovery oriented practice related to specific recovery focused indicators. Two facilitators were allocated to each site to guide discussions; at least one facilitator had a lived experience of mental health issues. A range of stakeholders, including people using RichmondPRA services, carers and staff incorporating the peer workforce were involved in the process of identifying the evidence. This paper will provide an overview of the internal appraisal process, including the strengths, challenges and participant responses to the process. Learning objective 1: Provide a framework to plan, implement and review an internal appraisal of organisational recovery oriented practice. Learning objective 2 .Participants will gain practical tips regarding measuring mental health recovery oriented practice.

#### **S094 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 01**

**Snapshots - Brief Paper 10 min: The Personal Helpers and Mentors Program (PHaMs): Investigation - Is long term participation within PHaMs, Recovery or Dependence?**

**Jill Steverson**

The Australian Government funded Personal Helpers and Mentors (PHaMs) program was rolled out in 2007 with an aim to support people diagnosed with a mental illness with 1:1 mentoring and support. This paper examines qualitative research from 4 PHaMs sites in New South Wales. The research concentrates on the cohort of participants who have stayed in the program for over 3 years. A large proportion of participants move through the PHaMs program within 3 years. However, there is a small proportion of participants in each PHaMs service who remain with the service long term. Data is collected to examine the overall demographics of this group and any geographical service issues that impact on the numbers and any influence regarding the new Employment PHaMs service. These long term participants are surveyed to examine their view of PHaMs, their journey and the challenges and benefits that have arisen from being part of the service for over 3 years. An investigation is also conducted with the service providers, to examine their view of the challenges for the service regarding this cohort, and review evidence of efficacy in providing support in excess of a 3 year period. The timing of this research is important, with it being 7 years since the program implementation. It is vital research not only to improve the current program, but also to examine the programs successes and failures and to make

recommendations to support potential funding into the future. **References:** 1.Is befriending by trained volunteers of value to people suffering from long term mental illness .2. Personal Recovery and Mental Illness: A guide for Mental Health Professionals M Slade 2009.

#### **S094 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 01**

**Snapshots - Brief Paper 10 min: Accredited Persons and Involuntary Detention and Admission. Costs and Benefits Analysis (CBA) of the implementation of Section 19, NSW Mental Health Act (MHact) 2007 No 8 (Detention on Certificate of Medical Practitioner or Accredited Person) at Fairfield**

**Joe Chuong Raymond Finch Rosellin Violago**

Strategies used to manage high caseload and workload at Fairfield Community Mental Health: facing the multiple challenges of increased demands for case management, increased complexity of consumers under care, the lack of clear guidelines / protocols and the lack of community resources for exiting consumers, a continuous quality improvement project was initiated and implemented over two years to manage these challenges and aimed to improve quality of mental health service provision to the local community and to prevent staff over-stress and burnout. Based on available evidence-based practices, each and all consumers are reviewed by the treating team and allocated a care level according to their diagnoses, mental state, social condition and functioning level and needs; clear criteria for entry and exit and specific guidelines are trialled and applied across 640 active consumers (average caseload of 30/each case manager). Pre- and post- clinical outcome measures, risk levels, functioning levels are used to evaluate consumers' progress and to indicate level of care and benchmark for the whole process of care. Basic demographic and pre- and post- clinical data on consumers involved are collated and analysed using SPSS to evaluate the whole process and aimed to find or identify a workable, achievable, measurable and sustainable pathway for the local community mental health service in the coming years. **Learning Objectives:** 1. Audience will gain a better understanding the factors behind the implementation of a large scale CQI project at a local community mental health during the 2 two years period; 2. This topic has been very relevant to the delivery of community mental health services: how the whole multi-disciplinary team contributed to the improvement of the quality of the community mental health service to the local community. **References:** RANZCP (2002) Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Schizophrenia and Related Disorders. Australian and New Zealand Journal of Psychiatry 2005; 39:1-30 Treatment Protocol Project (2000) Management of Mental Disorders ( Third Edition) Volume I & II. World Health Organisation, Collaborating Centre for Mental Health and Substance Abuse. Sydney.

#### **S094 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 01**

**Snapshots - Brief Paper 10 min: Echocardiographic Monitoring of Patients on Clozapine -Results and Clinical and Service Challenges.**

**Hannah Rose Beverley Pearson Joe Chuong Mark Cross Lilia Polewski**

It is well known that Cardiomyopathy can occur as a result of Clozapine therapy. Cardiomyopathy is best detected by Echocardiography. There are very few guidelines as to how frequently patients on Clozapine should have an. Echocardiogram. Pharmaceutical Company Guidelines are vague with up until recently- recommending Echocardiograms to be done between every 5-10 years. A recent Consensus of Treatment Refractory

Schizophrenia( Lambert et al) recommends Echocardiography every 2 years but recommendations from some Cardiologists suggest yearly. The authors undertook a systematic approach to Echocardiographic assessment of 120 patients within an outpatient setting. Some observations and results included:- significant challenges in getting patients to have Echocardiography due to individual and also Health Service factors.- a much higher than anticipated ~8% of abnormal Echo results. challenges in interpreting and managing abnormal results.- establishment of a liaison with several Cardiologists.- development of a protocol for Echocardiographic monitoring of patients in outpatient clinics.- development of guidelines for managing patients with abnormal echo findings. **Learning Objectives:** 1. about clozapine treatment, metabolic syndrome, cardiovascular risks management. 2. Echocardiographic Monitoring . Duty to Care Report . Preventable physical illness in people with mental illness-**References:** Lawrence D, Holman CDJ, JAblesky AV ( 2001) Perth: The University of Western Australia. Clinical implications of the CATIE schizophrenia trials: day- to ?day management lessons for Australasian psychiatrists. Bick P, Knoesen N, Castle D Australasian Psychiatry Vol 15 No 6, December 2007

### **S095 Consumer Experiences, Healing, Leadership**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 02**

**Paper 20 min: Speaking without fear: Voice Hearers teaching professionals how to respectfully work with voices**

**Robyn Martin Lyn Mahboub**

The Hearing Voices Approach (HVA) privileges the lived experience of people who hear voices. A HVA provides space and opportunity for people to explore, deconstruct and make meaning of their experiences (Dillon and Longden 2011). Within a HVA, voice hearing is positioned as meaning filled and meaningful, while also acknowledging the distress some people report which is associated with voice hearing. The Maastricht Interview was developed from research undertaken into hearing voices within the Netherlands in 1987 (Romme and Escher 2000). It provides a structured approach to exploring, deconstructing and making meaning of the voices experiences. The Maastricht Interview is designed to answer two questions 1: Who is represented by the voices? and 2: Which problems(s) do the voices represent (Romme and Escher 2000). This paper reports on Maastricht Interview training delivered through the partnership between Richmond Fellowship of Western Australia and Curtin University. Central to both training events was the paid employment of consumers with lived experiences of hearing voices. Consumers fulfilled the role of mentors and 'teachers' and shared their lived experiences. The consumer mentors facilitated growth in trainee skills; promoted positive changes in attitudes towards people who hear voices; deepened practitioner capacity to work in person-led ways; and increased participants' confidence to talk about and work with people and their voices. **Learning objectives:** 1. The audience will learn about: The Hearing Voices Approach, The content and purpose of the Maastricht Interview, The importance of co-creating opportunities for people with lived experience to enact educational mentor and trainer roles. The benefit for mental health professionals in learning from lived experience in areas such as confidence, skills and attitudes. 2. The Hearing Voices Approach is demonstrating its usefulness as a viable alternative to traditional psychiatric responses to 'auditory hallucinations'. Given the growth in the application of Hearing Voices Approaches worldwide, this presentation will provide a framework for understanding how the Maastricht Interview (as a part of a Hearing Voices Approach) can create opportunities for voice hearers to build a different relationship with their voices, based on self-determination and empowerment. The presentation has particular relevance for mental health professionals and organisations as it will discuss the how the training increased the confidence and skills of mental health professionals when it

comes to talking about and working with people who hear voices. **References:** Dillon, J and E Longden. 2011. 'Hearing voices groups: Creating safe spaces to share taboo experiences.' In *Psychosis as Personal Crisis*, eds. M Romme and S Escher. East Sussex: UK: Taylor & Francis. Romme, M and S Escher. 2000. *Making Sense of Voices - A guide for professionals who work with voice hearers* London, UK: MIND Publications.

**S095 Consumer Experiences, Healing, Leadership**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 02**

**Paper 20 min: 5 Keys to Recovery and Mental Wellbeing' – from the perspective of lived experience of psychological trauma, hearing 'voices', 'schizophrenia' and recovery.**

**Greg Ralls**

The aim of this paper is to help those people who experience 'voices' attain healing and recovery via adoption of a middle ground harnessing belief and individual assertion. For the author, voices are internal, inaudible and thought-like, and have resulted in a diagnosis of 'schizophrenia'. An antecedent of hearing voices, psychological trauma, is discussed from the personal perspective, in terms of lived experience. The challenges of recovery are highlighted in a candid exposition of the author's unique journey. Medical treatment of problems of living can be troubling to the individual and difficult to reconcile. Conventional medical and alternative modes of understanding are viewed with respect to voices, with the voices shown herein as being a clear response to overwhelming mental distress, evidenced by deep personal reflection upon a chronology of significant life events. A melded approach is adopted to define '5 Keys to Recovery and Mental Wellbeing'. A definite and strong focus is placed upon the practical relevance of simple to understand factors including families, lifestyle, and membership of the Australian workforce. Storytelling is demonstrated as a successful vehicle for healing, integral for taking ownership of one's experiences and essential, when supported, for the maintenance of wellbeing through self-empowerment.

**Learning Objectives:** The audience will gain an appreciation for the healing power of individual storytelling as a means of achieving recovery, as demonstrated through candid sharing of the author's lived experience. 2. All too frequently people entering services are passive recipients of care. It's postulated in this paper that severe mental health issues can be overcome through belief and self-empowerment, in a suitably supportive environment. This is highly relevant in an era when mental health services are often stretched and resources lean. **References:** 1. Romme, M., Escher, S., Dillon, J., Corstens, D. & Morris, M, (2009). *Living with Voices: 50 stories of recovery*. Ross: PCCS Books. 2. Watkins, J. (2006). *Healing schizophrenia: using medication wisely*. Michelle Anderson Publishing.

**S095 Consumer Experiences, Healing, Leadership**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 02**

**Paper 20 min: "Peace Mongering": Consumer leadership in building collaboration between consumers, clinicians, families and the community sector at the 2013 World Hearing Voices Congress**

**Indigo Daya Neil Thomas**

The consumer movement has been a strong advocate for change in mental health services, which can sometimes generate an unwanted dynamic of division. This remains an ongoing tension within the mental health sector, particularly when it comes to issues of human rights. All systems are naturally resistant to change, and those seeking change can often be seen as problematic outsiders - or they can find themselves colonised by the very system they originally wanted to change. A particular challenge for consumers can arise when, as we argue for change, we unexpectedly find ourselves exhibiting the very

behaviours that we are trying to shift, such as stereotyping or being dogmatic. The Hearing Voices Movement in particular has been a persistent advocate for practitioners paying greater attention to the experiences and wants of voice hearers. This has included advocating practices that help people learn to live with voices rather than seeking to eliminate them, and that give greater attention to the role of past traumatic experiences in hearing voices. Voices Vic, the peer-led program at Prahran Mission, has led the Victorian Hearing Voices Network since 2009 and has been advocating locally for these same changes. Voices Vic had managed to strongly engage consumers and the community managed mental health sector, but until recently had a limited relationship with clinical services. In hosting the 2013 World Hearing Voices Congress, Voices Vic wanted to create a conference that was consumer led, but which actively tried to bridge the usual divides between the clinical and research world and the usual audience of the Hearing Voices Congress. Voices Vic was also keen to bring more perspectives into the congress specifically families and friends of voice hearers, and different cultural and indigenous perspectives. In particular the congress organising committee was determined to actually demonstrate, rather than just describe, the changes we want to see in mental health: inclusion and respect, varying perspectives, non-violence, choice and collaboration. The congress was held during November in Melbourne, and titled: Journeys to Understanding: Sharing Experience, Expertise and Wisdom. This three day event was not only the largest ever World Hearing Voices Congress, but, with 770 attendees, it was the largest consumer-led event in Australia's mental health history. There were 119 sessions over eight concurrent streams, and more than half of these were led by people with lived experience. However we intentionally created a program which also included a range of prominent clinical, research, family and indigenous speakers. We took the unusual but successful approach of replacing almost all keynote sessions with round table discussions that brought together many different perspectives. This was an effective strategy bringing speakers towards shared ground. Our first roundtable discussion talked directly about the philosophy of the congress and was called 'A conversation about voices, non-violence and change' and it set a strong platform for the rest of the event. Another strategy was to make one of our streams PowerPoint-free. Rather than delivering presentations, speakers in this stream were required to demonstrate or lead practical activities in which we did the work, rather than talk about it. This stream resulted in some remarkably powerful sessions: laughter yoga, body work, sound meditation, sacred voice theatre, boxing, brain gym, and prayer and spirituality. The last afternoon of the congress employed the 'open space' or 'un-conference' format where congress delegates decided the topics for 26 separate sessions. This meant that every person could be a speaker, and led to many exciting new ideas and networks. Throughout the congress we also made available 'The Voices Wall', a large graffiti installation where every delegate could share their ideas. The congress was a resounding success on all fronts. We attracted delegates from all of the target groups: 25% clinicians, 12% carers, 20% consumers, 3% both consumer and carer, 12% community sector, 9% peer workers (19% not specified). Since the congress, a substantial number of new partnerships between Voices Vic and different clinical services have begun to form. The act of discussing change together, of listening deeply to each others' stories, and of working with a spirit of collaborative partnership has opened many new possibilities for the future. The paper will present brief learnings from strategies and collaborations at the World Hearing Voices Congress and then lead participants through a series of activities and discussions. **Learning objectives:** 1. To consider the factors that promote tension around consumer-led change in mental health, and ways in which we can overcome these tensions. 2. To share and learn new ideas about building respectful collaboration between the different sectors and groups in mental health. **References:** Corstens, D., Longden, E.,

McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the Hearing Voices Movement: Implications for research and practice. *Schizophrenia Bulletin*, in press.

Longden, E., Corstens, D., & Dillon, J. (2013). Recovery, discovery and revolution: The work of Intervoice and the hearing voices movement. In: S. Coles, S. Keenan, B. Diamond (Eds.), *Madness Contested: Power and Practice* (pp. 161-180). Ross-on-Wye, England: PCCS.

### **S096 Changing Mental Health Services Culture**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 03**

**Workshop 1.5 hrs: Coming Out (of the goldfish bowl): Breaking down the barriers and challenging the culture of mental health services**

**Peri O'Shea Cath Roper Anne Francis**

This workshop will explore the culture of mental health services and challenge aspects of this culture that have the potential to cause harm or trauma to both consumers and staff. The workshop will bring consumers and service providers together to discuss how the culture, practice, environments, and even talk, within mental health services create virtual and physical (such as the 'goldfish bowl') barriers between staff and consumers resulting in an 'us' and 'them' culture. This 'us' and 'them' culture blocks individual efforts to build the trust and rapport essential for recovery. Services with significant barrier cultures can also be very unsafe places for consumers to be, let alone recover. Furthermore, fear, discrimination and intolerance towards people who are unwell, which often underpins this culture, also makes these services very unsafe places in which to work. Significant number of clinicians also have episodes of mental ill health and many mental health service workplaces would be, arguably, the most unsafe workplace in which to disclose and seek the help needed. This workshop will explore issues such as involuntary admission and treatments, seclusion and restraint, fear and discrimination and out-dated codes of practice that stifle relationship building and increase the potential for people (consumers and staff) being traumatised within mental health services. The workshop will examine how the dominant culture is and can be challenged including the role consumers and consumer workers can play in breaking down the barriers. Furthermore, the workshop will explore what individual staff can do to challenge the culture so they feel safe coming out (of the goldfish bowl) and perhaps even disclosing a lived experience, if relevant, without fear of recrimination from their colleagues.

**Learning objectives:** 1. An understanding of the significant risks involved in not challenging the current dominant culture of mental health services-How to work together to develop ideas and strategies that challenge existing harmful cultures -Staff and consumers working together to develop an agreed plan forward . 2.How changing the existing culture of 'us' and 'them' will facilitate better Recovery Orientated Service Provision consistent with the National Recovery Framework-How changing the cultures which perpetuate fear, discrimination and violent practices will decrease the risk of primary or secondary trauma and better support Trauma Informed Practice within service-

Consumers and staff working together to improve services is consistent with the requirements of National Safety and Quality Health Service Standards Standard 2 - 'Partnering with Consumers'

**References:** Dr Cathy Kezelman and Dr Pam Stavropoulos 2012 'The Last Frontier' Practice guidelines for treatment of complex trauma and trauma informed care and service deliver. Adults surviving child abuse (asca) [www.asca.org.au](http://www.asca.org.au) Akiyama, T., Hamilton, B., Roper, C., Kanda, A., Buchanan-Baker, P., Barker, P., (2007) Effective & Humane Psychiatric Nursing: A Tidal Model, Australian & New Zealand Journal of Psychiatry. 41(1) supp 2, A185

**S097: Featured Symposium: Planning Services** (location: Riverview Room 4)

**29/8/2014 From: 1330 To: 1500 Venue:**

**Featured Symposium: From Grand Designs to Better Lives: Making Systemic Change Happen Symposium 1.5hrs**

Mary O'Hagan, Frank Quinlan

**S098 Wellbeing & Recovery**

**29/8/2014 From: 1330 To: 1500 Venue: Riverview Room 5**

**Paper 20 min: Service users' experiences of a physical activity programme in a community mental health setting**

**Arno Grueber Pauline Barnett Jeffrey Gage**

Research indicates that physical activity interventions in community mental health settings mediate service users' mental and physical well-being. However, little is known about how service users experience such interventions. In this presentation, the findings of a study with participants engaged in a physical activity intervention in a community mental health service in Christchurch, New Zealand, are described. Findings draw on semi-structured interviews to reveal participants' perspectives of the intervention, how they maintained physical activity over time, barriers to participation and recommendations for service improvements. The findings are discussed in the context of: How service users perceived the relationship between participation in the programme and barriers to exercise; How the service could be improved to meet the needs of the participants; How client-centred approaches can be used to develop and improve physical activity interventions. The outcomes of this study provide a better understanding of the implementation and evaluation of physical activity interventions for users of mental health services. **Learning Objectives:**

1. Attendees of the presentation will learn how to better understand service users' experiences with a physical activity intervention. 2 The topic of the presentation is relevant to inform mental health service providers how to plan and provide person-centred and evidence informed physical activity interventions for their service users. **References:** Grueber, A. (2013). Outcomes and experiences of participants of the Activity Based Experience (ABE) Programme at Richmond Services Limited: a mixed methods study. Grueber, A. (2013). The contribution of physical activity to recovery from mental illness. Oral presentation at the lunchtime meeting of Healthy Christchurch.

**S098 Wellbeing & Recovery**

**29/8/2014 From: 1330 To: 1500 Venue: Riverview Room 5**

**Paper 20 min: Let's focus on the positive: A practical framework for increasing people's wellbeing and promoting recovery.**

**Katy Robinson Amberlee Laws Rob Donovan**

The emphasis on recovery from mental illness largely focusses on psychotherapies and pharmacological intervention, whilst frequently neglecting simple lifestyle behaviours that can boost mental health and improve quality of life. The Act-Belong-Commit in Recovery project was developed to build the capacity of the mental health workforce to support and mentor consumers to engage in mentally healthy activities. As part of the project, workshops are targeted to mental health professionals and other support workers who assist consumers in their recovery journey. The workshops introduce The Act-Belong-Commit Guide to Keeping Mentally Healthy and how it can be used as a positive framework to support consumers in the recovery process. The overall aim of the project is to enhance recovery and prevent relapse by empowering individuals recovering from mental illness to get active, engage in the community and find meaningful things to do. The workshops were developed in conjunction with the Bentley Adolescent Transitional Unit and Ruah and then rolled out to the wider sector by offering workshops to mental health professionals and

other suitably qualified health professionals and support workers. This paper will introduce the Act-Belong-Commit in Recovery framework and present the findings of the evaluation. **Learning objectives:** 1. The audience will understand how they can integrate positive mental health principles into their work or their own lives. 2. This presentation introduces a positive framework that mental health professionals can adopt to support consumers to improve their mental health and overall quality of life. **References:** 1: Robinson, K., Donovan, R.J, Anwar McHenry, J. A Great Way to Live Life. The Act-Belong-Commit Guide to Keeping Mentally Healthy. Mentally Healthy WA, Curtin University, Perth, 2013 2. Jalley, G., Donovan, R.J & Lin, C. Evaluation of the Act-Belong-Commit Mentally Healthy WA Campaign, 2013 Survey Data. Centre for Behavioural Research in Cancer Control, Faculty of Health Sciences, Curtin University, Perth, 2013.

### **S098 Wellbeing & Recovery**

**29/8/2014 From: 1330 To: 1500 Venue: Riverview Room 5**

**Paper 20 min: From Little Things Big Things Grow – an insight into the contribution of the Self Help and Support Group Movement in the Mental Health Arena**

**Antonella Segre Stephenson Amanda Emilia Hay**

'The most common way people give up their power is by thinking they don't have any' Alice Walker. The paper will focus on illustrating the significant contribution of Self Help and Support Groups (SH/SG) towards the improvement of an individual's psychological functioning and effectiveness. It will delve into international and national SH/SG literature as a means of showcasing that mental health is an overarching condition which embraces all groups regardless of the specific condition that brings them together. There is no singular definition for SH/SG's other than that both are founded around mutual support, growth and recovery; based on the 'premise that people with a shared condition who come together can help themselves and each other to cope with the two way interaction of giving and receiving help.' (Borkman, 1977). They can be considered to be 'self-governing and to rely on the experiential knowledge of their members as the groups' source of authority.' (SG, 1999). The paper will define what and if there are any underlying differences within the use of SH/SG terminology. It will look at dispelling the perception that Groups are informal groups of people just having a cuppa but, endorse their ability of being effective Recovery Colleges in their own right. It will uncover the secrets behind the Groups' capability of having morphed into effective good practice models. It will look to International and National Literature which abounds with definitions, characteristics and ideologies attributed to SH/SG. The SH/SG movement has attained considerable attention in the last decade. Substantial literary reviews have focused on the role and benefits of participation. Research clearly articulates that for almost every presenting problem there is a SH/SG. ConnectGroups alone has over 600 members which span across Genetic, Chronic, Mental Health and Emotional conditions. There is an underlying expectation that those experiencing health and specifically mental health conditions are expected to live and receive treatment within their community. The frustration deriving from the families who care for those relatives including those with mental health condition has led to the growth of the SH/SG Movement. Focus will also be given around the demographic nature and characteristics of those that attend SH/SG with specific attention to those mental health conditions viewed as stigmatising and socially inappropriate. The role that carers play in this space will be discussed in regards to how pivotal they are to the recovery process of those they are caring for and how it cannot be underestimated. Carers in essence are viewed as the 'glue that holds the system together' (Chapman 1997) and how they can be defined as 'the paraprofessionals who play a significant role in their service delivery'. (Abramowitz & Coursey, 1989). The emotional support and information provision needs of the Carers will

also be showcased. The paper will emphasise the mental health benefits deriving from and individual's participation in relation to key therapeutic qualities such as opportunities for disclosure, empathic connection, shared goals and psychological adjustments to life challenges. 'Support Groups underscore the medical value of meaningful, group based programs whose focus elicits psychological and physical health benefits'. (Davison et al. 2000). Research conducted has demonstrated that those attending SH/SG's by being provided a safe space to share are able to decrease their negative emotions, form friendships and most importantly move out of a sense of isolation and re-engage with the community by re-establishing social networks. From Little Things Big Things Grow - an insight into the contribution of the Self Help and Support Group Movement in the Mental Health Arena. **Learning Objectives:** 1.The audience will be exposed to international and national literature reviews as to the growth of the Self Help and Support Group movement and their explicit role within the Mental Health arena. Including the direct contribution to the prevention and recovery process of each individual group member and their carers. 2.The topic is of relevance at a State level where the role of Self Help and Support groups has been identified through the 2020 Mental Health Strategy as being a key component within the person centred planning strategy towards recovery.

### **S099 Training, Supervision, Counselling**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 06**

**Paper 20 min: Are we making a difference? The use of the HSCL-25 in a torture rehabilitation counselling service for refugees.**

**April Pearman Alyssa Lillee**

The global increase in the number of asylum seekers and refugees has highlighted the existence of torture or trauma exposure and resulting mental health problems among this population. It has been documented that between 5 and 35 percent of the refugees residing within western countries are likely to have experienced some form of direct torture (Wenzel, 2007). Furthermore there is a multitude of recent research indicating that the experience of torture or trauma has resulted in elevated levels of poor mental health among refugee and asylum seeker populations, including instances of depression, anxiety and post-traumatic stress disorder (Charlson FJ et al., 2012, Husain et al., 2011, Rasmussen et al., 2010, Rees et al., 2013). Despite this, the utilisation of mental health services remains low (Correa-Velez I, Barnett AG, Gifford SM & Sackey D. 2011). In an attempt to understand reasons for this disparity, and offer more effective and relevant services, UWA and ASeTTS clinical team instigated the use of standardised instruments (the Hopkins Symptom Checklist - 25 and the Harvard Trauma Questionnaire) as part of standard practice and to assist with program evaluation. This presentation will address the process of this program evaluation, the procedural changes, the cultural shift required and outcomes of the study to date. **Learning Objectives:** 1.How to embark on and do culturally sensitive clinical research. 2.Is counselling helpful for refugee survivors of Torture & Trauma. **References:** Wenzel, T. 2007. Torture. Current opinion in psychiatry, 20, 491-496 10.1097/YCO.0b013e3282c3a5c1 Charlson FJ, Steel Z, L, D., Chey T, Silove D, Marnane C & Whiteford HA 2012. Predicting the Impact of the 2011 Conflict in Libya on Population Mental Health: PTSD and Depression Prevalence and Mental Health Service Requirements. PLoS ONE, 7, e40593. HUSAIN, F., Anderson, M., Lopes Cardozo, B. & ET AL. 2011. Prevalence of war-related mental health conditions and association with displacement status in postwar Jaffna district, Sri Lanka. JAMA, 306, 522-531.

### **S099 Training, Supervision, Counselling**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 06**

**Paper 20 min: Successful multicultural training in the most diverse state in Australia**

**Siew Ho Yeak Elizabeth Moore Alexander John Navneet Johri Mohan Isaac**

It is a requirement of the National Standards for Mental Health Services to have staff that are equipped to provide the best possible and culturally appropriate care to all consumers, their families and carers. **Learning Objectives:** We will present the evolution of a very successful Multicultural training program for Mental Health Services and partner organisations in WA. Method: We will describe the ten year evolution of training in this important area, the changing process of delivery and the changing syllabus to reflect contemporary changes in the Culturally and Linguistically Diverse profile in WA. Consumers and carers have been an integral part of this process. The decision to move to a train the trainer model allows more people to access this valuable experience and is responding to the need to adapt for sustainability, meeting changing needs of the community and our staff. Conclusions: Consumers carers and staff have reported better mental health outcomes as a result of this collaborative process what clinical supervision is, and its importance in these roles.

**S100 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 07**

**Snapshots - Brief Paper 10 min: Changing your life through employment, so that you are no longer defined by your diagnosis!**

**Carli Gettingby**

Employment changed my life and gave me a new way to define myself. My peers now considered me in light of my achievements and relationships, rather than my mental health diagnosis or former psychosocial disability. My passion is to help other people with mental health issues to also achieve social inclusion, confidence, personal value, skills development and financial resources through employment. People with a lived experience deserve to work just like everyone else, however there are many barriers and participation statistics are grim. We need to create the conditions to self-empower those with a lived experience to have the same opportunities of employment as other members of the community. Individual Placement and Support (IPS) is an evidence-based model of excellence, and improves access to employment for people with mental health issues. I will share my journey of involvement with the WA Association of Mental Health and their State-wide IPS Project. Colleagues have been generous in imparting their knowledge and expertise, and have respected the value of my insights and contribution. Making a difference in the mental health sector has redefined my standing in the community, and I am leading a life full of hope, optimism and social inclusion. **Learning Objectives:**

1. People in the audience will learn that people can and do recover from mental illness to lead a contributing life. Sharing my personal journey of recovery through employment will help to reduce stigma and discrimination. 2. Through my advocacy, recovery through employment is now on the national agenda for mental health consumers and carers involved with the Mental Health Council of Australia. **References:** In Australia, people with disability are only half as likely to be employed as people without disability. In 2010, Organisation for Economic Co-operation and Development ranked Australia 21 out of 29 countries in employment participation rates for people with disability. (Federation of Ethnic Communities? Councils of Australia, 2014). While approximately three quarters of people with mental illness are typically excluded from the competitive labour market, evidence suggests that a large portion of individuals want to work and have the ability to work, especially when evidence based practices are in place. (WA Association of Mental Health, 2011)

**S100 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 07**

**Snapshots - Brief Paper 10 min: Specialist Aboriginal Mental Health Service - Who, What and Why?****Mark Booth Deanne Lewis**

The Specialist Aboriginal Mental Health Service (SAMHS) is a small dedicated multi-disciplinary team consisting of Aboriginal and non- Aboriginal staff each from various backgrounds with a common goal of improving the health outcomes, both physical and psychiatric, of Aboriginal clients engaged by our service. SAMHS has a 'no wrong door' philosophy. Identifying alternate and/ or more appropriate service provision for individuals, and where necessary, case management to clients that for various reasons do not or are unable to access mainstream services. For the majority of our clients SAMHS's provision of care is based upon a shared care model, working alongside local clinics and services allowing improved relationships, faster and responsive management and improved outcomes for the individual and a reduction to the impact of ill health both physical and psychiatric to that of the family and community. SAMHS is also committed to the provision of cross cultural support, education and understanding to communities, services, families, individuals and within its own organisation. SAMHS supports a pathway for Aboriginal workers to gain a Bachelor in Health Science (Mental Health) improving professional development and presence within the health workforce. **Learning Objectives:** 1. Our audience will leave with a clear idea of what we provide as a service and how to access us. 2. SAMHS Metropolitan key service intent is to enable all Aboriginal people in Western Australia to have their mental health needs met through seamless service provision that is culturally and clinically safe, appropriate, and effective. **References:** In 2008 COAG set specific and ambitious targets for Closing the Gap The first target is: To close the life-expectancy gap within a generation SAMHS holistic approach attempts to ensure both the physical and psychiatric health of the individual is assessed and appropriate care is provided or offered. Reconciliation Action Plan ? North Metropolitan Health Service. The NMHS RAP affirms the commitment to strengthening partnerships and creating new ways of working with Aboriginal people that are based on shared values of Respect, Acceptance, Honesty, Openness, Transparency, Patience, Trust and Integrity.

**S100 Snapshots****29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 07****Snapshots - Brief Paper 10 min: The Yarning Circle****Silvia Tedeski Leanne Franklin Margaret Jones**

**Learning objectives:** 1. Working with Indigenous communities effectively; 2. Enhanced social & community connection, honouring stories and improved wellbeing. The journey of four local services (partnership) in forming connection with local Indigenous carers- building trust and empowering individuals to access services. Sharing hopes and dreams about the future while honouring individual and national history. Addressing shared experiences of isolation, grief, loss and disadvantage. Planning for the future, building friendships, strengthening relationships, having fun together, building resilience and meeting carer needs

**S100 Snapshots****29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 07****Snapshots - Brief Paper 10 min: Reducing Stigma related to mental health in CaLD communities through the use of bi-cultural trainers.****Tamar Lea Susan Laval Yassaman Rezvani**

Stigma related to mental health has been seen to exist in all communities throughout the world and is known to be an obstacle when it comes to both seeking help and gaining knowledge about mental health issues. It is known that early detection and early

intervention of mental health problems results in better prognosis and stigma has a negative impact on this. Although mainstream Australian culture has seen the benefits from Mental Health promotions aimed at decreasing stigma, CaLD communities have not. Due to the fact that stigma is a social construct, it is imperative that this is addressed and tackled in both a culturally relevant and culturally sensitive manner. Fremantle Multicultural Centre took advantage of funding that became available for a project entitled Stepping Out of the Shadows - Reducing Stigma in Multicultural Communities. The intention of this program was to reduce stigma within CaLD communities. The aim was to build upon strengths within these communities, using their varying traditions and ways of thinking to help them deal with stigma and mental health issues. This was achieved using bi-cultural trainers who were known within their communities. This project will be discussed both from the perspective of Fremantle Multicultural Centre and from the perspective of two bi cultural trainers from differing communities.

### **S100 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 07**

**Snapshots - Brief Paper 10 min: A Right to Recovery: Let's talk about the Elephant in the Room**

**Graham Robinson**

'Recovery' is the currency of mental health consumer groups around Australia, and now a principal term of reference in Govt policy and service systems. Despite its adoption there is a discrepancy in its interpretation from the consumer and clinical perspectives. From the consumer perspective 'Recovery' concerns human flourishing in a social context - an individual's unique experience; from the clinical perspective it remains a matter of symptom diminution. The latest mental health initiative - Partners in Recovery targets individuals with complex needs who slip through the gaps of service provision, and as the name implies it is delivered within a Recovery framework. Complex needs suggest co-morbidity, consisting in drug & alcohol issues and personality disorders. This paper focuses on the problem of personality disorders in mental health service provision and the likelihood that such co-morbidity leads that category of individual to fall through gaps. This is in part explained by the abovementioned discrepancy. From the client's perspective there's mental distress typical of Axis I conditions; from the service perspective it is a feature of the personality disorder, considered untreatable. PIR is about facilitating systemic change. This paper examines the problem and possible remedies. **Learning Objectives:** 1. The audience will gain an insight into what is undoubtedly an exclusionary factor denying some individuals the right to assistance on their recovery journey. 2. The audience will accept that, if recovery oriented practice is adhered to in the PIR Program, personal experience, not diagnosis - should be the foremost consideration in plugging the gaps in service provision. This will lead to a much more collaborative approach. **References:** Australian Govt., Dept. of Health & Ageing - Partners in Recovery - Information Paper 1 (July 2012) MIND Australia - Models of Recovery Oriented Practice, 2012

### **S100 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 07**

**Snapshots - Brief Paper 10 min: Voice Hearer make great parents**

**Amanda Waegeli**

Families can be vitally important for recovery. However often the system and services do not work to include the family but only to exclude. Assumptions about what is best for the family are often to remove children from parents that hear voices, in the child's best interest. It does not have to be this way. A child's best interest is to maintain a relationship with their parents in good and challenging times and this builds resilience. The aim of this

presentation is to challenge these assumptions and show how parenting with voices is possible and can have positive benefits for both children and parents. Using my own personal and professional experience I will share how to talk to children about their parent's voice hearing experience and promote a healthy journey of family recovery. I will share strategies for parenting as a voice hearer. Parenting can be a challenge at the best of times. Parenting whilst living with voices can be just one of those normal challenges, but it is possible and can have great outcomes. Discussions with over 30 voice hearers who are parents from around the world were had in preparation for this presentation. **Learning Objectives:** Learn strategies to assist families in talking about hearing voices drawn from over 30 families from the world hearing voices movement. Discover the benefits of sharing challenges with children and family members to help strengthen relationships. Lyn Mahboub: 0416 161 321 Senior Recovery Advisor, Richmond Fellowship Kerry Hawkins: 0403 961 498 Carer Advocate Nth Metro Health Services

### **S101 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 08**

**Snapshots - Brief Paper 10 min: Does the word 'Consumer' best define the specific title, duty & role among our MH Consumers of today with an ever shifting MH system.**

**Evan Bichara**

We all know the word consumer is mainly used in Australia's MH services & is documented widely throughout ALL MH National, State & Territorial policies, discussion papers from various organizations / government throughout Australia - is it the correct term to truly define who consumers of the MH services are what they do to empower themselves & others towards recovery & in improving / reforming the overall services throughout our country. This paper endeavours to examine this questionable definition widely looking at what participants of the MH services are being called overseas & whether the word consumer would continue to be the most practical word to define the MH users of today in our ever changing landscape of MH services being provided. WE look at different local support / advocacy groups & their different names & why they have chosen those names - their views about the term consumers used to define themselves. WE also investigate what the term consumer implies within the services of today & examine possible alternatives of what might be to many people a more accurate definition.

### **S101 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 08**

**Snapshots - Brief Paper 10 min: The Victorian CALD Reference Group - an effective group to addressing needs & MH reform in the Multicultural MH area of work.**

**Evan Bichara**

This paper will point why it is essential to have the Victorian CALD Consumer group continually active addressing the Multicultural MH Agenda from the lived experience. The group has been a vehicle for renewed skills, confidence, direction / enthusiasm for keen consumers/carers of the MH system who wish addressing the Victorian CALD Agenda. Above all, it allows people working within their own agenda - collaborate with good people doing good things / helping to change Victoria in accepting the MH Multicultural Community. It allowed people also to dispel lots of the myths / stigmas that were heard whenever people declared their illness to the wider community including the ethnic populations of Victoria. Developing connections between people became a powerful tool to recovery for many participants of the group - which allowed a friendly environment where people may get well / learn their own way. Many members claimed to feel good - to be doing something positive / extremely worthwhile helping & informing so many people. The work that changes attitudes / cultivates good / innovative ideas which generates a good feeling knowing they are

helping others indirectly / or directly reaching recovery. I will talk about our achievements & important milestones cultivating a sustainable & vibrant group. **Learning Objectives:** 1.The audience will learn / gain what many merits are involved with running a Multicultural focused group of different talents / abilities. Also the potential in creating established enthusiasm / good charisma among group members can be rewarding not only to the group itself but to every member participating.2.There are not enough Multicultural MH Groups established across this wide multicultural country of ours. This paper hopefully will endeavour to encourage further advancement in this field creating a more equally / dignified society looking after our MH immigrant consumers Australia wide. **References:** Ray of Hope:Reflections of Community Development experiences: Gordon Knowles,The National Agenda for the Multicultural Australia: Sharing our Future: Office of the Multicultural Affairs.

### **S101 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 08**

**Snapshots - Brief Paper 10 min: Ryde Consumer Network 20 years of service, how the sharing has made us strong**

**Paula Hanlon Michael Appleton**

The Ryde Consumer Network was first established in 1993. After 20 years of service to the consumers and the mental health service we reflect on how the sharing has created a stronger consumer voice and a stronger mental health service. The National Mental Health Standards (2010) Standard 3, 'Consumer and Carer Participation' identifies what can support strong participation. This includes 'involving consumers in planning, service development, evaluation and quality programs' (3.1), providing training and supporting to maximise representation and support roles (3.3, 3.5), the role of employment and supervision (3.6) and the policies and procedures that enable participation (3.7). The presenters, Michael Appleton (founder of Ryde Consumer Network) and Paula Hanlon (Manager, Consumer Services) will outline the structures and practices of the group that have made it successful. These include a representation group, a role for volunteers, a welcoming consumers' space, facilitating of recovery groups by consumers for consumers, individual and systemic advocacy, social engagement, consumer forums and consultation and evaluation with action plans and feedback. The presenters aim to show how these structures and relationship building and effective communication with clinicians and management have created a strong mental health service that welcomes and encourages consumer participation. **Learning Objectives:** 1.The audience will gain an understanding of how successful consumer participation can be established and a strong partnership developed with the mental health service. 2.Consumer participation is essential for recovery focused mental health services and achieving success with the National Standards for Mental Health Services (2010).

### **S101 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 08**

**Snapshots - Brief Paper 10 min: Don't Lose Your Marbles**

**Douglas Holmes**

The purpose of the paper is to explain how a community event in 2012 raised awareness and broke down stigma with a fun event that involved activities with marbles and information sharing from the local community of Northcott and Surry Hills in Sydney Australia. The aim was to raise awareness and break down stigma with a fun event that involved activities and information sharing for the local community.'Don't Lose Your Marbles' was held on Sunday 14th October 2012 at Ward Park in Surry Hills. In keeping with the theme of 'don't lose your marbles', marble activities including a guessing competition and marble run - were held. A range of local agencies were represented and

brought information along. Agencies and working group members contributed an amazing amount of marble cakes for the day which worked well with the coffee cart donated by NEAMI on the day. The City of Sydney provided a great BBQ. Tenants and local residents dropped by during the day. The event was an excellent example of collaboration between local social housing tenants, NGOs, Housing NSW, Police and Health. The event has now turned into a yearly event and more information is available at [www.cosnp.info](http://www.cosnp.info). **Learning Objectives:** 1. People attending the workshop will learn about the steps we went through to engage the community and the organisations that came forward to support and contribute towards the event.

### **S101 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 08**

**Snapshots - Brief Paper 10 min: Resourcing outcomes through communication**

**Claire Green**

Navigating the Mental Health system can be difficult especially when you can't articulate your needs as a patient to a mental health professional. Claire Green is in the unique position of being both a caseworker and a patient which gives her an intricately detailed perspective of how the mental health system operates. From this perspective she presents a new way of forming beneficial partnerships between mental health professionals and their clients through effective communication. Expressing one's needs when one is unwell is not easy whilst being a professional also comes with its own set of restraints. However, both need to include communication as their key tool in empowering good outcomes. For example, Why is it that when Claire goes to see a psychiatrist he not only fails to explain the pros and cons of medication but also skims past her inability to articulate symptoms? How can we bridge this gap so positive support is provided? It is crucial we have a mutually beneficial exchange but how? It starts with dialogue and communicating explanations of why decisions are made. It involves modelling ways of articulating symptoms, whilst defining clear goals. In this way both the professional and the client are empowered. **Learning objectives:** 1. They will learn that when someone with mental health issues is silent in the treatment room it does not mean blind acceptance of that treatment or recovery service. Nor does it mean that the person will comply with the treatment regime, recovery programme or the medication, in fact they may intensely dislike being told what to do instead of being advocated for by a caring other. The audience will learn that until people feel self-empowered through equal conversations they will not feel heard and that feeling heard leads to a vital connecting relationship where education and information provided can lead to better outcomes for both patient and professional. 2. The partnership and dialogue between two people within mental health services can be far more important in the long run than the treatment regime, because effective communication provides the foundation for recovery to be achievable. Doctors and support staff cannot support the patient if that patient does not know what he or she is meant to be focusing on and monitoring. At the same time, how can a partnership be formed if a shared framework is not put in place to work towards recovery? Positive communication is arguably the most important aspect of ensuring positive outcomes within the mental health system. **References:** 'Recovery: An Alien Concept?' By Ron Coleman (2011) 'PTSD workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms' By Mary Beth and Soili Poijula (2010).

### **S101 Snapshots**

**29/8/2014 From: 1330 To: 1500 Venue: Meeting Room 08**

**Snapshots - Brief Paper 10 min: MI Recovery: a viable and recovery oriented program for a changing sectoral landscape**

**Cassy Nunan**

With changes in service delivery landscapes (introduction of the NDIS etc), it's crucial that community mental health organisations offer evidence based programs within their suite of offerings. MI Recovery is a peer designed, evidence based, peer-led education program, imparting information about mental illness and recovery knowledge; as well as peer support to assist in planning a healthy lifestyle. Latrobe University research results indicate significant participant outcomes in areas of stigma resistance, connectedness, illness management and empowerment. Mental Illness diagnosis often results in loss of rights and selfhood. Peer-only domains offer a unique space for reframing and reclaiming these necessary aspects of self (Solomon, P, 2004). As a short-term intervention that enables consumers to reclaim their skills, rights and outlook, towards a fulfilling and meaningful life, MI Recovery is well-suited to the changing landscape. It is available for delivery within any organisation, clinical or community setting and can sit comfortably with broad ranging service delivery suites. This paper will discuss the structure and delivery style of the MI Recovery program. Qualitative findings and the Latrobe University study outcomes will be presented to demonstrate the effectiveness and necessity of peer-delivered programs in an increasingly recovery focussed sectoral environment (Davidson et al, 2007).

### **S102 Changing Systems**

**29/8/2014 From: 1330 To: 1500 Venue: Amcom Suite**

**Paper 20 min: Collective Impact Principles for Diverse Communities**

**Fadzi Mutambiranwa**

Large-scale social change requires broad cross-sector coordination, yet the social sector remains focused on the isolated intervention of individual organisations (Kania & Kramer). Community engagement around mental health with the Culturally and Linguistically Diverse (CALD) communities should be broader than an individual organisation's approach. Building cross sector collaborations will create partnerships that promote knowledge sharing. The principles of Collective Impact could provide guidance in developing sustainable community engagement strategies that would benefit all. The Collective Impact framework is a structured and disciplined approach to bringing cross-sector organisations together to focus on a common agenda. Setting a common CALD community engagement agenda through knowledge sharing will result in better understanding of the mental health attitudes, stigma and discrimination faced by CALD communities. This involves better coordination of services between government departments, not for profits, community organisations, business sector and individual communities. Adopting a common framework targeting the CALD community and their networks would compensate the time and resources some organisations have spent on research and learning. Lasting change will occur when we begin to create a common agenda centred on engagement strategies with CALD communities would provide a platform to share knowledge, contacts and provide better understanding of existing and new communities. **Learning objectives:** 1. (i) How to develop a community engagement plan and engage with ethnic communities through a broad cross sector approach. (ii) How mental health service providers adopting a collaborative community engagement strategy will assist in better understanding the people accessing mental health services. 2. Partnering with individual communities to break cross cultural barriers will assist in developing and strengthening community engagement strategies aimed at: (i) Raising awareness of individual needs (ii) Educating communities about mental health issues (iii) Empowering communities to build their capacity for problem solving and decision making thus developing and strengthening their networks. This helps service providers better identify barriers to accessing mental health issues faced by CALD communities and partnering with individual communities to tackle these barriers.

**S102 Changing Systems****29/8/2014 From: 1330 To: 1500 Venue: Amcom Suite****Paper 20 min: Sharing a Common Agenda in practice: what 2 different Partners In Recovery Organisations have learned using the 'Collective Impact' approach.****Marcia Barber Raphael Chapman Eleanor Bayliss**

This paper will demonstrate that a shared agenda and the impact of collective action as a set of organising principles has the effect of making a stronger more resilient service sector, whilst incorporating the existing local matrix of strength and will in other partners to create best practice solutions. [R. Chapman - Presenter 1] One of the most notable features of the current mental health sector is its failure as an integrated service system. This has led to fragmentation of innovation and piecemeal quality improvement in services to consumers. The need for service reform can be seen as the rationale behind National initiatives such as the Partners in Recovery model. This coordinates service delivery to people with complex mental illness in a way that fulfils the sustainable outcomes and wrap around services promised, but not delivered by previous attempts at collaboration and interagency processes. However, the program implementation requires an organising framework that is sufficiently rigorous to manage and achieve sustainable systems reform. This paper will develop an understanding of how a Collective Impact framework is being used to create five key outcomes in systems and service reform within the implementation of Partners in Recovery. Specifically the nature of Program management through consortia framework; use of the consortia management to define systems reform KPI's for Program implementation; sustained synergy of commitments to service response through development of a single care plan; provision of facilitated commitment and performance against the care plan through a coordinating agent to monitor service relationships and problem solve committed actions. [M. Barber - Presenter 2] The PIR initiative in ACT began with solid Collective Impact (CI) bang: Everyone around the table that could be got there, and lots of optimism and good will about what could be achieved for people with severe and enduring mental health difficulties in the ACT, and an expert - and costly! - Facilitator in CI guiding us through. This presentation will give a nuts and bolts account of what happened next in our Collective Impact implementation of Partners in Recovery program, and an honest account of the high points and the pitfalls. 6 months into operations, we have found the principles of CI an excellent place to begin, and a good methodological approach to guiding our thinking about how to tackle the systems gaps and blockages our PIR clients ('participants') are coming up against. While we haven't maintained a 'true' CI approach all the way through, the ideas and principles of being the CI backbone: (guiding vision and strategy, support aligned activities, shared measurement practices, building public will advancing policy and mobilize funding) have been our guiding light for tackling the thorny issue of system change in a practical and systematic manner. **Learning Objectives:** 1. Attendees will gain insight of the synergies across Australia in systems reform whilst feeling inspired to return to work with renewed motivation and some strategies of how to reach outside the box to achieve innovation in their own programs. 2. Successful complex system navigation is positively impacting on the opportunity for individuals to positively embrace a journey toward health and wellbeing particularly recovery journeys for people with complex mental illness. Collectively impacting on a complex system creates stronger more resilient service provision to support and provide for individuals their families and carers for sustainable wellbeing. **References:** 1: Kania. J., & Kramer. M., (2013) Embracing Emergence: How Collective Impact Addresses Complexity. Stanford Social Innovation Review, 5(63). Viewed online 2: Commonwealth of Australia (2013) A National Framework for Recovery-Oriented Mental Health Services. Canberra. Online ISBN: 978-1-74186-013-9.

## Conference Closing

**1530 – 1630**

**Riverside Theatre**

Handover of Banner to Canberra Committee 2015

Presentation of prize for best poster