25 Paper: HOW WE TACKLE THE TOUGH QUESTIONS! EASTERN VIEW COMMUNITY CARE UNIT LIVING IN THE COMMUNITY A REALITY Julie Rowse, Terry Gleeson. Independent living in the community, how do we get there? There are several barriers that make the goal of living in the community difficult to obtain. The role of Community Care Units is to help overcome these barriers to make living in the community not just a dream but a real possibility. Some key issues that need to be addressed to make community living a reality include medication, smoking, finances, and consumer input. Compliance on medication is essential for success in the community. The need to manage money is critical particularly for smokers as cigarettes consume a significant proportion of one's income. Given that the majority of consumers smoke, sixteen out of twenty clients at Eastern View CCU, this is an important issue. Without consumer in0ut how can we know we are providing the clients with the best opportunity to succeed. This paper aims to address these issues by providing information about how Eastern View Community Care Unit currently deals with the following questions. How do we teach clients to be responsible for taking their own medication and be compliant? How do we empower clients to manage their own cigarettes? How do we encourage clients to take responsibility for their own fiancés How do we gather and use feedback from our clients to improve our serve?

28 Paper: BOUNDARIES – AN EVOLUTIONARY SHIFT! Paula Hanlon As the human evolutionary development enters a new millenium another evolutionary shift is occurring within mental health. The therapeutic relationship between mental health professionals and consumers has traditionally been "protected" by boundaries. Professional and personal boundaries were set in place to maintain a safe working relationship where the roles of the consumer and mental health professional were well defined and understood. Professional boundaries are set to protect consumers from exploitation and violations such as sexual abuse. Mental Health Professionals require professional boundaries to maintain reasonable expectations and prevent burnout. The presenter aims to expand the experience of boundaries to address the importance of personal boundaries. Lewin's Personality theory describes a boundary as "any hindrance or impediment to the person moving (metaphorically) from region to region in the life span" (Reber,1985). The presenter will examine the shift in personal boundaries between Mental Health Professionals and Consumers as an important aspect of the recovery process. People can be affected by the initial onset and/or diagnosis of their mental illness/disorder, stigmatized by an interruption to their emotional and social development. During the recovery process there can be an awareness of the lost knowledge, skills and opportunities created by the halt in human development. The Mental Health Professional may be the closest person the consumer trusts and looks to for direction. Psychopathological recovery requires the professional knowledge and response of Mental Health Professionals. Emotional and social recovery requires the personal sharing of experiences and the encouragement of risk taking. For this to be effective the sharing must be honest and personal, with mutual trust and respect the most important ingredients of the interpersonal relationship. For this to be successful the personal boundaries must 'shift' to allow recovery to be complete.

132   Paper: "CROSSING THE CHASM": WOMEN AND THE PUBLIC MENTAL HEALTH SYSTEM IN THE LODDON MALLEE REGION. Wendy Lauder,Sally Moulding" Crossing the Chasm" is the culmination of a 12 month consultative process involving women who have used the mental health system either as clients or carers. Many services and organizations were visited by the independent project workers, Mary Fraser and Cate Nunan, and these service providers contributed a range of comments. This project was in response to the Victorian Governments document "Tailoring the Service to Meet the Needs of Women" As a result of the broad consultative process, a Strategic Plan was developed to be implemented within a 3 year time frame. The key areas of the plan are:1. That services respond to the needs of women with a mental illness who are parents.2. Provision of services that are responsive to the needs of women with experience of sexual assault.3. That inpatient and residential services provide

women with adequate safety and privacy.4. Delivery of services that are responsive to older women.5. Provision of services that are responsive to the needs of women who are carers.6. Increasing participation of women in Psychiatric Disability Support Services. 7. Provision of services that are responsive to the cultural needs of women who have a mental illness.8. Providing services that are sensitive to the needs of women living in rural and isolated areas. The key implementation strategies are as follow:1. Setting up a reference group of all the key stakeholders Consumer representative- Area mental health service personnel- Relevant service providers ie CASA- Non government organizations- Koori representative2. Internal working party3. Workshops across the region for clients, carers and workers. 4. Presentations to other relevant service providers ie Division of General Practice.

170 Paper: SEX! WE'VE GOT THE SKILLS, BUT ARE WE DOING IT? Zoey Doueal, Tracey Pearce The significance of a successful sexual relationship is frequently overlooked in the treatment of clients in public psychiatry. The minimum usually attended to is assessment of sexual dysfunction for diagnostic purposes and side effect screening. This appears to occur despite the fact that clinician's should already possess generic clinical skills such as anxiety management and communication skills that can be readily extended to provide therapeutic intervention in the areas of sexuality. Impairments in sexual function can be a result of biological factors or medication side effects, however, is also significantly impacted upon by more complex cognitive processes such as self-esteem. Therefore, it is imperative to address sexual dysfunction in a rehabilitative sense to facilitate improvement in self-esteem and subsequently enhance interpersonal relationships. This paper aims to highlight why sexual problems are often overlooked in the treatment of mental illness and the negative impact that this has on rehabilitative process. Most importantly, the presentation reflects in a practical sense ways in which clinicians with basic generic skills can assess the needs of the client with sexual difficulties and outlines the skills required to implement basic therapy. Intervention when sexual difficulties are present is important in a rehabilitative sense – we have the skills as mental health clinicians, but are we using them to full advantage to educate and assist our client population?

253 Paper: 'THEY MUST BE DREAMING!' - WHO'S TRUTH BEHIND THE HEADLINES? Ani Southern
Ani Southern will be presenting a performance style paper on images of mental ill health in the media and the impact that some news stories can have on individuals and their communities. The presentation will include a piece of drama using an actor intercut with information in a presentational format and will then be open for discussion. The drama will enact the same event(s) in different ways - eg, from the news media's stance, from the view of the person who was unwell, from the perspective of community members and from the family's viewpoint. What will be revealed is the differing realities of these groups and individuals and the thinking (the dreams, hopes or fears) behind their views of reality. The aim of this paper is to provide an opportunity for delegates to explore other realities in terms of the media representations of mental health consumers.A former member of the National Council of the New Zealand Journalist's Union (1992-94), Ani Southern currently works for the Mental Health Foundation as part of the Mental Health Promotion team as Project Manager for the consumer component of the Project to Counter Stigma and Discrimination Associated with Mental Illness as well as working on policy and resource development. In this paper, she draws upon her experience in journalism as well as her experience working over the last ten years with both consumer and non-consumer organisations in Aotearoa/New Zealand including the Health Funding Authority, Aotearoa Network of Psychiatric Survivors and the Ministry of Health.

256 Poster: HELP! PROJECT Suin Ni Chrochuir The HELP! Project aims to give witness to women's experiences of getting help (or not) with the Alcohol & Other Drug concerns in their lives. The project participants are women whose own use or that of someone close, now or in the past, has made them look for help. The project began by creating a space for women's stories in group workshops, taken further in a Creating Group, who in turn have taken their 'story of the stories' back to a Community Feedback session, and forward again towards forming a documenting event – the video story of the HELP! Project. The participants are committed to the importance of being HEARD – taking the powerful words and meanings of their experiences beyond the individual, to be of use to other women, as well as to service deliverers in the business of giving 'help'. The HELP! video is currently at pre-edit stage, with post production of a 20 minute broadcast quality video and project completion scheduled for June. The HELP! Creating Group wish to present the story of this video and Project in the form of a General Poster – preferably incorporating the video itself on continuous play. The Poster will have relevance for all conference participants but most especially those for whom Alcohol & Other Drug concerns have a place in their life/work. The open, honest stories of HELP! address basic concepts, in ways that are at once encouraging and provocative, allowing the viewer to gain and support their own clear understandings of the principles of help. The very special nature of a participant run, worker facilitated, process led project will be clearly illustrated for the viewer, with all the learning this brings. The HELP! Project is an initiative of The Woman's Centre – an independent, NSW Dept of Health funded, women's counselling

1 Paper: REHABILITATION – THE CREATIVE WAY Liz Newton Successful community mental health rehabilitation requires creative solutions to turn dreams into realities for consumers. Working in partnership with the Ryde Consumer Network, the CREATE Team [Community Recreation, Education Access, Employment and Training] of the Ryde Community Mental Health Service, aims to achieve this through seeking and grasping opportunities for consumers. CREATE is one strand of our comprehensive rehabilitation service. The other strand is the Community Rehabilitation Team [CRT] which focuses upon case management. The two components allow each team to specialise which ensures that consumers have their needs met appropriately, effectively and efficiently The CREATE Team is a truly unique multi-disciplinary team and challenges traditional rehabilitation health service models through the employment of non clinical personnel to meet the broad needs of clients. The three components of CREATE are managed by staff skilled in each area. A health professional [social worker] collaborates with a consumer Social Committee Co-ordinator for the recreation and leisure aspects of our program. A teacher heads the education and training access area which focuses upon linkages with mainstream educational facilities such as TAFE, and a Business Co-ordinator is responsible for the day to day management of the commercial enterprises of a Café, function facility, property and garden maintenance, landscaping and cleaning business. Vocational trainers skilled in each aspect of the business enables on the job training and support for consumer employees. The team also seeks funding opportunities from a variety of sources to provide pathways into employment and training. This paper will examine some of the issues surrounding the CREATE model including whether providing access to training, education, work and recreational activities is an appropriate ground for mental health services to pursue. The CREATE model can demonstrate effectiveness in this service, however, it is only through the challenging of traditional ideas that it continues to evolve.

2 Paper: HOW GREAT IS CASE MANAGER'S WORKLOAD? HOW IS IT MEASURED? **Lenore Meldrum, Peter Yellowlees**. Objective: There has been little work designed to objectively quantify case manager caseloads and in most services these continue to be variable. The aim of this study was to develop an appropriate scale to accurately assess the level of clinical load each case manager at the Valley Integrated Adult Mental Health Service in central Brisbane carried.   This involved the adaptation of, and further adjustment to, a scale originally developed at the Chatswood Community Mental Health Service to facilitate more effective and appropriate allocation of clinical cases to case managers. Method: Survey of, and consultation, with about 40 Case Managers over a period of nine months was used to gather data and modify the monitoring tool for future use in the service. Results: Analysis of the data gathered revealed that case managers carried an average case load of 13 clients and spent on average of 51% of their time in case management. Their average clinical load was recorded as 154 points on the Scale. The data showed that if they had been working as case managers for 100% of their time their average nominal clinical load would have been a score 319 points. Using the scale individual caseloads were divided into patients who were Low, Medium and Heavy service Users. This division was made to assist the case managers and discipline seniors in monitoring their clinical load and proved to be useful in clinical supervision. This paper will present the results of 18 months data gathering as well as positive and negative comments from a number of case managers regarding the Scale.

3 Paper: WHEN STIGMA SCREAMS THE SILENCE IS DEAFENING Sami Ryan This presentation explores stigma and the impact on women and their families. There are two parts to this paper. Part one examines the regard and treatment of the mentally ill through the ages. How the media, movies, television etc perpetuates the stigma, thus influencing societal acceptance of such labelling. The stigma of mental illness can impact on all aspects of one's life, including a mother's opportunity to care for her children. Part two looks at the effects of psychosis on a woman and the effect this has on her children who were removed from her care to be raised in foster care. Although the children themselves suffered no mental illness they also carried the stigma of the mother's diagnosis and other problems due to

the breakdown of the family unit. The presentation is accompanied by props I have made which add visual impact to the words.

4 Paper: IMPROVING POSTNATAL OUTCOME Anne Buist, Carol Morse, Jeanette Milgrom, Sarah Durkin
Fourteen per cent of women develop a depressive illness postpartum; a majority of these women are not seen by Mental Health Professionals, though their illness may be chronic and have significant impact on the family and their child's development The authors report on a project conducted over three years, where education and liaison with Maternal Child Health Nurses and General Practitioners aimed to improve recognition, community management, and improve liaison with specialist mental health services. Outcomes of women will be reported; a majority were managed successfully in the community, but lack of local services was highlighted by both the women and the MCHN's. GP attendance was poor, but MCHN's were positive and enthusiastic about the education and liaison. Regional differences in support services and the effect this had on community management will be highlighted.

5 Paper: **CHILDHOOD ABUSE, DEPRESSION AND PARENTING Anne Buist** A psychosocial model for potential transmission of psychiatric illness in some families will be presented. Reference to the literature, and the authors recently completed a three year follow up study of women admitted to a mother baby unit with postpartum depression, half of whom had abuse histories, will be included, as well as case illustrations. Childhood abuse predisposes to adult depression; its occurrence in the postpartum period potentially disrupts the mother-child relationship, with ongoing ramifications for the relationship and child development. Women who have had poor parenting experiences are potentially at greater risk of these ongoing difficulties. Involvement of Mental Health professionals in the early identification, management and prevention will be opened for discussion.

6 Paper: A CONSUMER FOCUSED APPROACH TO CLINICAL LETTER WRITING Pamela Phease With the dawning of the new millennium it is time to revisit the medical model approach to mental health and examine some of the ethical issues that arise within it. One such issue is "How can we meet all the clinical requirements in this system while making the consumer central to the ownership of knowledge, rather than the Health System?" This presentation will focus on clinical letter writing as one of the ways in which this issue can be addressed. The aim is to outline a consumer-focused style of writing clinical letters, which is based on a narrative therapy approach and has been adapted for use within the Mental Health System. Instead of only focusing on the illness or symptoms as is usual in medical correspondence, this approach acknowledges the consumer in a more holistic way and yet still maintains communication amongst interdisciplinary team members. The paper will outline narrative therapy and its relevance to clinical letter writing, give the developmental background of this new approach, provide some examples of consumer-focused clinical letters, and share feedback from consumers which highlights the difference for them between traditional medical letters and a consumer-focused letter style. The presentation will provide psychiatrists and other health professionals a chance to think about what they are writing, for whose benefit they are writing and how they can use clinical letters both as a therapeutic tool and to meet clinical requirements.

7 Paper: THE INITIAL MEETING – JUST HOW LONG WILL FAMILIES WAIT? Valda Dorries, **Sally Young, Theresa Hamilton, Robert King** Over the last decade, mental health agencies have faced an increasing challenge to provide effective responses to the length of waiting time for service. Lengthy waiting lists are problematic for child and youth services, for both clients and staff, given the need for timely interventions. Increasing consumer demands for accessible and effective treatments, in combination with resource constraints and economic restrictions, place considerable pressures on mental health agencies to meet these concerns and implement responsive programmes. In what has been described as a "climate of substantial crisis" (Price, 1994), the development of the single-session consultation model has been one innovative response to these concerns, with an increasing number of Australian agencies following trends reported from overseas. In this context, this paper describes the results of an impact evaluation study of a consultation model of service delivery, which was introduced in June 1995 at the South Brisbane Child and Youth Mental Health Service. The concept of a Consultation model was developed following consideration of a number of issues affecting engaging families in therapeutic work: long waiting lists mismatch of expectations (client and service)lack of brief therapy orientation early detection of abuse need for timely intervention During 1997/98 a large research project (n=900) was undertaken to evaluate the model and to explore its implications for service delivery and staff training. The project provides evidence to support the Consultation model as a strategy in wait time reduction and consumer satisfaction. Overall, the results of this study are supportive of a significant relationship between the duration of wait-time and rate of client attendance.

8 Paper: HUMANISED MENTAL HEALTH SERVICES: AS IMPOSSIBLE AS FLYING TO THE MOON? Helen Gibbs The hope for humanised mental health services is often felt to be a distant, if not unachievable, dream. Yet not so long ago the same thing would have been said of landing on the moon. The speaker maintains that the humanisation of mental health services is not a distant dream, but an achievable reality. In a series of ongoing invitations, she invites staff to fully employ their authority to bring about change within the mental health sector. She argues that is it not enough for staff to satisfy themselves that they are doing all that they can within current constraints. Instead, they must fully consider the circumstances of other human beings and commit to doing all that is necessary to bring about change. The onus is not on consumers and carers to teach staff about what partnership really means. The onus is on staff to learn about consumer and carer experiences so that effective and humane services can be provided. The speaker will discuss social activism, as initiated by Mahatma Gandhi and later applied by Martin Luther King Jr. in

the black civil rights movement, as an approach to negotiation that might be employed by service recipients within the mental health sector. She will outline the objectives and activities of the Mental Health Reform Alliance which will employ social activism to insist upon recognition of human rights within the mental health sector. Finally, the speaker will strongly urge that staff who are committed to learning about the issues, experiences and recommendations of service recipients attend the consumer and carer run Our Lives Our Choices Conference.

9 Paper: CONSUMER EVALUATION TOOL Jon Kroschel This 'Consumer Evaluation tool' has been developed solely by Consumers and is in the form of a 20 question questionnaire. It contains questions within the domains of Information (Medical, Diagnosis, Relapse Management, ISP's, Rights) Supports (Frequency with Doctor/ Psychiatrist, Length of time with Doctor/ Psychiatrist, Availability of other Staff, Nature of support given by other Staff) Involvement (Community, Family, Personal Development, In Control of own Life) and a Domain specific to a service aspect (for CCU it was Housing (Adequate, Choice of who live with, Decision Making processes, Groups run).These domains and questions were requested by Consumers as highlighting their relevance for service improvement. Being modular in design the tool enables the withdrawal of the CCU relevant questions of housing and the insertion of questions relevant to another service aspect (MST, CCT, CAT, Inpatient).The tool enables gathering of quantitative information by asking what is the 'ACTUAL', what would be the 'MINIMUM' and what would be the 'IDEAL.' The tool gathers information of both a quantitative and qualitative nature. A database has been developed that produces a report containing the collation of the statistical, quantitative information in a form that services easily understand and managers can easily respond to by reallocation of resources where necessary and also reports the Consumers qualitative feed-back for further discussion within Consumer groups, Staff groups and Consumer-Staff collaborative groups for response development. The data base has the ability to systematically sum the quantitative and qualitative information so that as well as each service aspect receiving reports relevant to them, management can also receive summary reports of 'Rehabilitation aspects' (CCU and MST), 'Continuing aspects' (Continuing Care Team), and 'Intensive aspects' (CAT team and Inpatient) and a final report of the Consumers evaluation of the entire service. This tool is unique in that it has been Consumer developed and produces reports that management can easily respond to. This paper will present more information about its development, its structures and its utilization.

10 Paper: HATS, COATS, GLOVES AND GLASSES Jon Kroschel The role of Staff-Consumer Consultant, Consumer Consultant or Consumer Adviser, working within Public Mental Health Services in a Quality of Service Improvement role as part of Consumer Participation Projects is an extremely unique position. No other role requests of an individual to stand, and work, squarely and securely in the centre of the rift of difference of perspective between what the services and staff see and what the Consumers see. From this unique position it is easier to observe the systemic and intrinsic humanistic mechanisms that inhibit effective communication between the two parties (Consumers and Staff) that true Consumer Participation is reliant on. This paper explores these barriers in the form of 'hats, coats, gloves and glasses', the similarities of these for both sides, the differences that are unique to each side and how and why both sides utilize these as both 'protection' mechanism and 'power attaining/retaining devices'. Suggested mechanisms to overcome these barriers will be explored. Practical examples of what has been tried and their outcomes will be discussed, utilizing the mechanism of exploration for solutions that 'practical', 'actual' situational examples enables. This paper utilizes the mediums of song, theatricals and other visuals to covey the knowledge (gained through experiential learning by the author during his 3 year employment to the role of Consumer Consultant) of the use of 'hats coats, gloves and glasses', but never disguising the information and message this paper delivers.

11 Workshop: CONSUMER PARTICIPATION......A PRACTICAL DEMONSTRATION WORKSHOP Jon Kroschel Whilst within Public Mental Health Services, Consumer participation is said to be embraced and services constantly pay lips service to wanting to change and improve, the fundamentals for enabling the cultural change and mind set shift that come through discussion of practice in 'Consumer Only Groups' and 'Staff Only Groups', and the exchange of these discussions and then further discussion in 'Consumer/Staff Collaborative' decision free groups has been ignored, inspite of research showing that this process is fundamental to communication across difference of perspective and fundamental to real change in any service system. With the pressures from economic rationalization of services, no space is allocated for the thinking, discussion and reflection on what services are doing or the impact of what they do. For Consumer Participation to achieve its aims, space within the 'service delivery model' needs to be made for discussion. Until people have seen and experienced these principals of Consumer Participation, many will still be providing the barriers whilst loudly expressing their support and knowledge of Consumer Participation and its fundamental purposes and principals. This workshop is a practical demonstration model of these purposes and principals and will be entirely audience participatory. It takes the question of 'Why can't Consumers write their own Individual Service Plans?' and places this into a group of 'Staff Only', selected from the audience, for discussion. It takes the question of 'What would you write into you own Individual Service Plan?' and places this into a group of 'Consumers Only', selected from the audience, for discussion. Summaries of these two group discussions are then exchanged for further discussion by each group. A final joint 'Staff and Consumer group' (the entire audience) will discuss summaries of discussions and discuss the effects of this process. This workshop will enable participants to learn from experience:1. The need for these types of group discussions within Consumer Participation Projects.2. The benefits to communication that this process enables.3. What are the fundamentals of 'Deep Dialog' or 'Socratic' discussion groups.4. How these differ from the usual decision making groups.

12 Paper: THE SOUTHERN AREA FIRST EPISODE (SAFE) PROGRAM Graham Garland A growing body of research evidence suggests that early intervention in psychosis is likely to reduce the incidence and severity of the cognitive problems and debilitating symptoms associated with psychoses. This has given rise to an abundance of literature stating what mental health services should do in order to provide Early Intervention Services. The literature typically addresses how matters such as engagement, assessment, medication, family intervention and relapse prevention ought to be managed. However, there is also a body of literature, which suggest that simply handing these protocols to mental health staff is unlikely to allow the service to embrace early intervention practices. This paper discusses how one rural area, the southern Area Mental health Service (SAMHS) attempted systematically to take the literature pertaining to early intervention and convert it into digestible components, allowing their service to methodically incorporate these new practises into everyday operations. The SAMHS addressed issues such as, what do we mean by 'early' intervention, how do we ensure access and what best practice interventions should occur? These matters raise questions in regard to the organisation of the service and the education of staff. Other services may benefit from considering how this rural service has attempted to introduce best practice in early intervention.

13 Workshop: A MULTI-MEDIA PERFORMANCE: MR MANIA,CULTURAL CONNOTATIONS OF MENTAL ILLNESS,WITHIN A YOUTH CONTEXT Kris Jasper, Paul Barron, Paul Raeburn, Anthony Todd Weller Through the use of costumed performers enacting a loose narrative in a theatrical space, Mr Mania will examine popular perceptions of mental illness, concluding that labelling and stereotyping are ultimately socially destructive, eg. these perceptions can be constructions that effectively limit or repress political and artistic freedom and therefore progressive ethics. These constructions will be illustrated as conscious, unconscious and socially engineered. To contrast, emerging definitions of illness not yet acknowledged will be included, prompting the underlying (possibly unanswerable) questions: just what 'is' society's definition of mental illness? Is there a dialectic relationship between social standards and mental illness (eg. anorexia) and where does this blur the line of personal freedom and choice? Although ultimately serious, humour will be injected through scripted words, actions and voice-overs that highlight some of the hypocrisy and excesses of both the attitudes toward mental illness (inherent in public, media and clinical discourses), and the institutions that define the illnesses and support the sufferers. Popularly held assumptions and expectations of the mentally ill will be challenged, alternatives to attitudes and treatments will be offered. By no means comprehensive, the aim is to provide different points of view to a subject that is often misrepresented or ignored, providing platforms for further discussion rather than answers. We will endeavour to avoid trite and patronising solutions, respecting that mental illness is a complex and distressing issue. Nevertheless, we believe a performance art forum (by providing visually interpreted ideas rather than reams of text and facts) can be useful in relaxing the stultifying and depressing atmosphere usually apparent when mental illness is discussed. The narrative will introduce a group of models (each representing a visually interpreted mental illness) and attendants backstage as they prepare for a fashion parade, follow them through the parade hosted by two contrasting MCs (in voice-over - one in following a fashion discourse in a camp male voice, the other a clinical discourse in a matronly female voice) and conclude with an after-show party and post-mortem back in the dressing room (where medication replaces the red wine and canapes). The fashion parade structure will be used to find analogising concepts of insecurity, image and public display. Finally, an interview of the fashion designer by a major TV station - questioning his mental stability. The script was developed using personal narratives of consumers of a mental health service. A narrative perspective was utilised as it contributed to a framework through which people know themselves- their construct of self. The narrative attempts to help people with a mental illness separate from their problems. It can involve deconstructing and reconstruction practises by 'externalising' an approach that encourages persons to objectify, and at times personify the problems they experience as oppressive (White 1998) White. M. (1988) The externalising of the problem and the re- authoring of lives and relationships. Dulwich Centre Newsletter 4: 6-28 The set will be a space representing a dressing room behind a catwalk (established through projections of mirrors with super imposed images of past and present situations on a separate forward scrim. The Photography, lighting and motion continuity will be strictly planned in order to create the illusionary 3D space within the virtual audience projections to mirror how the characters persevere in their environment. The illusion is made complete by using a mixture of prerecorded material, textures, live mixing and projection motion. Video, slide projection and gobo slide programming will be mixed by practioners during the performances.The costumes will represent aspects of a range of clinically defined mental illnesses, styled using recognisable details (colours and shapes) from the juvenile series of books and cartoons, Roger Hargreave's 'Mr Men' as well as details laden with meaning and visual puns. (see below for detailed costume notes for each character) The Characters Main Characters: Mr Bad (Borderline psychosis - business suit covering a metal exoskeleton), Mr Happy (mania, Bi pola r(B.A.D.) - yellow armour of smiley badges and body paint with a tail he chases), Mr Mad (Schizophrenia - clear PVC Venetian blind gown, rotating halo of symbols of police, UFOs, CIA, church etc), Miss Forgetful (Dementia - Long lacy drape with nostalgic objects - dolls, photos, silk flowers etc) Supporting Characters: Miss Thin (Anorexia - Bound with corsets on stilts, scales on her shoes, sick bag as handbag), Miss Bump (Borderline Personality Disorder - Panadine and Medication boxes, razor blades, syringes), Mr Confused (Drug induced psychosis - hat styled as clown shoes, other garments sculptural and mismatched), Mr Sad (Psychotic Depression - Industrial costume of TV and urban environment objects weighing him down, he's hunched and has restricted movement).By

attending this conference we hope to discuss preconceived ideas of labelling and stereotyping of people who have an experience of mental illness and there treatment.

14 Paper: THE USE OF LIFELINE TELEPHONE COUNSELLING SERVICES BY CLIENTS OF MENTAL HEALTH SERVICES Andrew Rolfe, Bruce Turley, In 1997, Lifeline Australia received funding from the Commonwealth Department of Health and Family Services to enhance the reach of telephone-counselling services for young people at risk of suicide. This grant was made as part of the federal government's national youth suicide prevention strategy. The program developed by Lifeline over the past two years included a significant evaluation strategy. The evaluation strategy includes anonymous caller profile data on over 20,000 calls and a four month follow-up study on a small sample. Lifeline's data on suicide and more general calls show extensive use of crisis telephone counselling services by people with a wide range of mental health problems. The role of telephone counselling as an early intervention accessible pathway to further professional help and community support for people with mental health difficulties will be discussed. The paper also highlights ways in which telephone counselling complements other professional services by providing interim ongoing support for clients with a mental disorder. Options for improved networking and linkages between telephone counselling and other service providers will be presented. The paper will also review of the difficulties callers have in accessing services, and the outcome of calls to Lifeline. The outcome evaluation describes the services that Lifeline callers are referred to, and the level of problem resolution they achieve after their call to Lifeline.

15 Paper: THE PRACTICALITIES OF IMPLEMENTING AND INTEGRATING THE NATIONAL MENTAL HEALTH STRATEGY IN COMMUNITY MENTAL HEALTH: A SOUTH AUSTRALIAN PERSPECTIVE. **Varga, Lana and Thomson, Delrene**. The move towards community based services has evolved over a number of years under the direction of the National Mental Health Strategy, and more recently, the Second National Mental Health Plan. Southern Mental Health, in conjunction with local consumer/carer advisory groups, have attempted to redirect services from traditional central institutional care, to a broad-based community service which strives to provide better access and services to meet the needs of clients with an emerging or ongoing mental illness. Mobile crisis teams, a range of case management services, specialist therapeutic services, and greater community linkages are but a few of the changes to the structure of community mental health services. This paper will discuss the evolutionary process from inpatient to community care, and how this transition has occurred and functions well, despite financial constraints which sees some inpatient services still confined to a traditional central institution.

16 Paper: "BIZARRE" ART EXHIBITION: A JIGSAW OF CONTRIBUTIONS CREATES A POSITIVE PICTURE. Peter Rodgers, Julie Neild On 19 February, 1999, Peter Rodgers' dream of having a one-man art exhibition became a reality with the opening of 'Bizarre' at West End Community House in inner-city Brisbane. This event was an affirmation of the ability of those with schizophrenia to achieve, and positively contribute to their community. In this paper, Peter will outline the journey of his dream to reality, as he recovered from a psychotic episode. Peter's story raises various issues worthy of exploration, including: How does one develop the belief in oneself, so necessary for achievement? Who decides what will be "helpful" for a person and when this should be undertaken? How does the general public react when someone declares himself a "schizophrenia sufferer" in a local newspaper article? The 10 Year Mental Health Strategy for Queensland, 1996, outlines a policy context including the fostering of intersectoral links. Such policies may be viewed as the dreams which give direction to the provision of services, aiming to bring about the realities of recovery and the maintenance of well being. This art exhibition was a concrete demonstration of intersectoral links in operation - organisations working flexibly with one another towards a common purpose – the realisation of a consumer's life goals. Peter currently receives services from the Division of Mental Health of the Princess Alexandra Hospital & District Health Service. Peter's Care Coordinator there, Julie Neild, will outline the contribution of various agencies towards the realisation of Peter's dream and also how the exhibition itself, enhanced communication amongst these agencies. A visual record of the exhibition will be presented to illustrate and inspire.

17 Paper: THE STRENGTHS MODEL IN ACTION Paul Liddy, Jane Pemberton This paper talks about the introduction of the Strengths Model* as the method of support for PACT community and residential services and our enthusiastic reaction to the model. PACT is a community trust which provides various levels of social and practical support for over two hundred people with psychiatric disabilities in Otago and Southland, New Zealand. In our experience, and despite good intentions on everyone's part, efforts to support people using the psychosocial rehabilitation model often become stuck at the needs, deficit, and pathology end of the support spectrum. This has the effect of creating a negative space for people where their illness and deficits are the main focus of interest and intervention. By using the principles of the Strengths Model, which encourages people to concentrate on their strengths, dreams, and visions for the future, we are able to help them into a positive space that has the ingredients of hope, expectations of growth, personal development, achievement, and recovery. The paper will discuss the process used to share the vision of the model with all the people involved with our service, the response to that sharing and the changes that began to take place in our service provision and development. We will share stories of the impact these changes have had on individuals and the hopes and dreams we have for the future using this model as the template for support

18 Workshop: FROM CHAOS TO COLLABORATION AN EXPERIENCE OF DISSOCIATIVE IDENTITY DISORDER Andrea Taylor, Paula Hanlon Multiple Personality Disorder, referred to now as Dissociative Identity

Disorder (DID) is a clinical disorder acknowledged by the DSM IV (1994). Generally, DID is misunderstood, misrepresented by 'Hollywood' media, thus poorly recognised and managed. DID is a complex reaction to severe trauma, a survival coping mechanism for people who experienced severe child abuse, including sexual abuse. As an expression, dissociation allows the total person to continue functioning. The complex arrangement of personalities, however, have their own unique histories, behaviour and thought patterns, social constructs and even physiological reactions. Identifying DID is difficult in that other factors often coincide. Drug and alcohol addiction, self mutilation, homicidal and suicidal ideation, auditory hallucinations, paranoia, cognitive disruptions and thought blocking, eating disorders and sudden changes in mood and behaviour may all exist in the persons presentation. Addressing each as an individual clinical diagnosis may result in the misdiagnosis of the underlying disorder, that with treatment can reduce the effects or existence of these other problems.   As a disorder treated within the scope of Mental Health Services DID has one of the best prognosis for long term recovery. However, not treated effectively there is a high disruption to daily functioning, high demand on Mental Health care and high suicide risk.The presenters of this workshop, case manager and consumer have worked together to present practical strategies on management of DID. The workshop aims to provide participants with a general overview of the environmental, social and cognitive factors that contribute to the development of DID, the experiences of a person living with DID, and some strategies for recovery. The extensive range of circumstances, experiences and strategies for recovery cannot be fully covered within the scope of this workshop. The presenters will provide a glossary of terms, and a list of resources to further develop participants understanding of DID. Participants will be actively involved in experiential exercises designed to provide the opportunity to experience living with DID in a variety of daily settings. The interactive sessions, interspersed throughout the workshop will empower participants with skills to assist in the detection and management of DID.

19 Paper: DESCRIPTION AND EVALUATION OF THE CENTRALISED INTAKE SYSTEM IN A RURAL MENTAL HEALTH SERVICE Wayne Rigby, Tim Leggett This paper describes the operation and evaluation of a centralised Mental Health Intake System within a rural area of Southern New South Wales. A centralised Intake System was Implemented in the Southern Area Mental Health Service (SAMHS) in Mid 1998 after a study conducted within the Area concluded that a centralised system was superior to the existing localised system, and appeared to be most likely to provide an effective and efficient Intake system, most appropriate to the need of the Area and its clientele. Among the notable features of the centralised Intake system are that all Intake calls to the mental health service are triaged through a single point of entry which is a 1800 telephone number, and then appropriately passed on with standards protocols of response. This line is staffed 24 hours per day, 7 days a week by trained mental health professionals. However, it was evident that the performance of the new Intake system would need to be closely monitored and evaluated to ensure that it achieved its potential. This paper presents an interim evaluation of the system now that it has been running for 6 months. On balance the system is performing effectively and cost efficient. Over the next year a more detailed and on-going evaluation will be conducted.

20 Paper: THE DESIGN, IMPLEMENTATION AND EVALUATION OF A "BEST PRACTICE" RURAL ACUTE PSYCHIATRIC IN-PATIENT UNIT. Wayne Rigby, Tim Leggett This paper will document the design and evolution of a Best Practice clinical project in a rural psychiatric in-patient service. It will consider some of the major concerns of mental health provision in rural areas and problematise its practice and policies. Psychiatric in-patient care in rural areas comes in many forms and serves a widely dispersed, heterogeneous group of stakeholders. The project was designed first to determine and then implement the characteristics and operating policies of psychiatric in-patient "Best Practice" for such an area. The initial process involved wide-ranging discussions with stakeholders, including general practitioners, general hospitals and mental health services, and clients and their families, in order to determine the key desirable features expected from a rural in-patient psychiatric service. Evidence from the literature was compared and contrasted with the specifics of the area and a design for Best Practice procedures and policies constructed. This included salient features such as an acknowledgement of the scarcity of specialised health resources, the distances involved and isolation of many communities, the impact of modern telecommunications and the centrality of a community-based mental health care system which often lacks the support of an institutional infrastructure. Several controversial aspects became apparent as the project developed. These included the question of who ought to be the gatekeeper of a psychiatric unit, admission criteria and practice, the differential benefits of in-patient care, the role of the general hospitals and Special Care Suites in the management of psychiatric clients and policies to ensure continuity of care for clients as they move from a distant community setting to a psychiatric unit. In summary the paper hopes to stimulate discussion and debate, and provide an opportunity for all rural mental health services to learn from the experience of this service in providing excellence in in-patient care.

21 Paper: THE ANTENATAL NEEDS OF WOMEN WITH A PSYCHOTIC DISORDER Linda Byrne, Jo Barkla, Jenny Hearle, Karen Plant, John McGrath The Queensland Centre for Schizophrenia Research has been conducting a study examining the antenatal needs of women with a psychotic disorder. This study involves interviewing women with a history of psychotic disorder and well controls in the first, second and third trimester's of their pregnancy, and then twice post-natally. The aim is to use information collected in this study to improve the knowledge of health care workers, reduce stigma associated with this group, promote engagement of these women into

antenatal care and assist them with the transition to parenthood. Preliminary results of this study will be discussed including; a) that this group of women have significantly higher rates of unplanned pregnancies; b) women with a history of psychosis report different levels of bonding with their parents than well controls; c) women with a history of psychosis develop strong bonds with their babies; and d) this group report significantly more distressing life events than do women without a history of psychosis. While results of this study are not yet complete, it is clear that women with a history of serious mental illness have different needs to those without. Our preliminary data indicate that psychotic illness does not impair parental bonding and attachment. Implications of this study include the need for preconception counselling and the need for a collaborative approach between psychiatric and obstetric services.

22 Paper: BOUNDARIES - WHAT ARE THEY? Desley Casey, Gwen Scotman In this paper we propose to discuss the various issues which surround consumer participation and or employment within mental health services on the issues of boundaries. We propose to discuss strategies for overcoming and/or the incorporation of boundaries, which provide a safe environment for consumers as well as health workers. The Collins National Dictionary (1976) p. 66 defines boundaries as :"... a border or limit; a dividing line; barrier ....."Some of the issues surrounding boundaries are : * setting limits on the amount of consumer participation or what the service considers appropriate for consumers to be involved in; * the possible inclusion of boundaries between consumer representatives, advocates or workers and who they represent;* the boundaries or the placement of boundaries between consumer workers and other staff. These are some of the challenges we all face in order to ensure that consumer participation become a success story rather than a horror movie for all concerned. We need to question whose reality are boundaries incorporated into. Some difficult situations can arise due to the excessive placement or absence of boundaries. We need to set and stick to reasonable, healthy limits in our participation. Maybe this a pre-requisite to forming genuine partnerships. We need to have boundaries that do not complicate life rather we need boundaries that simplify life. We cannot look at consumer participation and employment in isolation of the boundaries which each of us set - whether these boundaries are healthy or unhealthy. Many consumers have or have had dreams to participate. We need to take the reality, shake it up, toss it around, open the bag of dreams and decide - whose reality do the dreams belong to.

23 Paper: MY DREAMS MY REALITY Natalie Andrew In this paper I would like to share my experiences as a young consumer, now twenty-four (24), growing up through the last six years with a mental illness. The journey through the last six years has been a long one. I've lost a lot and learnt a lot. My dreams have changed dramatically because of my present reality. I have battled with social isolation, wrong medication, loss of self esteem, and wrong diagnosis through my journey to get well. My biggest dream was always to have a musical career, but this dream has become lost in my present reality. I went from playing the piano for four hours a day to not playing at all. However, at the same time I have benefited in many ways from my experiences. I have made great new friends and have learnt a lot about myself. My dreams are much simpler now - to live and enjoy my life as fully as the next person. Without my dreams and determination I would not have held down a job that I love for two and a half years as a consumer advocate and four years as a young people's consumer representative. Sometimes I wonder where I'd be now if I hadn't become a consumer.

24 Paper: TOWARDS THE DEVELOPMENT OF A CONSUMER GENERATED GOAL INDEX (CGGI) Robert Bruseker Lindsay Oades Peter Kaputi The National Standard for Mental Health Services (1997) requires consumers and carer participation at all levels of the mental Health Service. This project is paramount when it comes to setting goals with consumers. This paper describes an innovative model of psychological rehabilitation, namely, the Collaborative Rehabilitation and Advocacy with Individualised Needs (CRAIN) model. This model requires that mental health care is centred around collaborative goals setting and monitoring based on individualised needs in contrast to traditional symptom based approaches. Within this model individual needs are identified using the Camberwell Assessment of Needs Short Appraisal Schedule (CANSAS), collaborative goals based on these needs are set using a modified version of Goal Attainment Scaling (GAS). This process is demonstrated with examples from two consumers in an outpatient rehabilitation setting. Where consumers have identified specified goals and with each goal associated strategies are developed and implemented. A continuum of possible outcomes is specified ranging from achieving the expected level of treatment success or outcome to the attainment of more than expected level of success with treatment intervention. These goals are formulated and specified with sufficient precision that an independent observer can determine the point at which the patient is functioning at any given time. Future developments of this process are discussed in relation to (i) quantifying the relative importance of goals from consumer's perspective, yielding a 'consumer generated goal index', and (ii) providing an individualised outcome measure that is easy to use, requires little training and emphasises collaboration between consumers and clinicians.

26 Paper: THE EFFECTIVENESS OF CASE MANAGEMENT: WHEN IS THE EVIDENCE GOOD ENOUGH? Stephen Ziguras, Geoff Stuart, Dean McKenzie[1,3] There have been dozens of studies into the effectiveness of case management in mental health over the last 20 years and at least 20 literature reviews. While most reviews have concluded that case management is effective, a recent meta-analytic review by Marshall and colleagues as part of the Cochrane collaboration concluded that case management (excluding assertive community treatment): 'approximately doubles the number of hospital admissions with little evidence of causing an improvement in mental state, social functioning or quality of life'. These findings have been widely discussed and critiqued. We conducted a meta-analysis (statistically combining the results of previous studies) of studies of the effectiveness of case management in mental

health. Our methods were similar to those used by Marshall, but with less restrictive inclusion criteria so that more data could be analysed. Our findings match Marshall's as far as hospital admissions and drop-out rates from services are concerned but we also found that case management decreases total days in hospital, improves level of social functioning, client satisfaction and symptomatology, and decreases family burden of care. Overall our conclusions about the effectiveness of case management are positive and starkly different to those of Marshall. How could this be, given that we have examined the same body of previous research and similar methods? This paper will briefly present the results of our meta-analysis, and highlight the differences between our approach and Marshall's, both in terms of methodology and results. We will also report the results of analysing outcomes of studies by different inclusion criteria (such as study quality, or including only previously published measures) to examine whether these in fact make a difference to the overall findings. In other words, what does the evidence say about applying different rules of evidence? Finally, this paper raises some questions about the nature of 'evidence' and judgement used by researchers and policy-makers.

26.5   Workshop CHANGING MENTAL HEALTH SERVICES - THE ETHNIC MENTAL HEALTH CONSULTANTS' PROGRAM Stephen Ziguras, Lena Andary,   **Jenny Hussin,; Christabel Quiah,; Jorge Torrico, Yvonne Stolk**,; This workshop will focus on the process of bringing about change within mental health services by discussing the work of the Ethnic Mental Health Consultant's (EMHC's) Program in Melbourne.Numerous research studies and reports have documented problematic aspects of delivering mental health services to ethnic minorities in Australia. In response, the Victorian Department of Human Services established the Ethnic Mental Health Consultants' Program in 1996 as one way of improving service delivery to this group. Each of the major metropoitan hospital networks received funding for four years to establish an EMHC position to work with mental health services it managed. Five positions were funded in Melbourne, with some funding also provided to rural areas to support similar work being conducted by existing staff. The Victorian Transcultural Psychiatry Unit provides coordination and support to the program. This workshop will start with an overview of the program and the work undertaken. The major part of the workshop will be devoted to discussion of a number of themes which have arisen through the work of the EMHC's. These themes will be posed as questions to be discussed by a presenter and the audience. They include: Change from whose perspective? How do you decide what change is necessary and provide the opportunity for a range of groups to have input into this process? In particular, how do ethnic communities and consumers of non-English speaking background influence these decisions, and are they heard by mental health services?Top-down or bottom-up?Do top-down approaches from policy makers and managers (such as policy documents developed by government departments, or targetted funding, or quality bonus incentive schemes) actually bring about change? What are the advantages and disadvantages of top-down approaches? What about bottom-up approaches (those developed by consumers, ethnic communities, and/or clinicians), and what are their advantages and disadvantages?How do EMHC's bring about change?What are the strategies and initiatives which have been used by EMHC's to change policy and practices? Which strategies do not work and why? What is possible and what impossible? How do staff and consumers influence management decisions about allocation of resources and time?What are the strengths and weaknesses of the EMHC program?Based on 2-3 years experience of staff in the program, what are its strengths and weaknesses? Does the way the program is structured influence what it can and does achieve? How might it be improved in future?

27 Paper: WHEN DREAMS BECOME REALITYAN EXTENDED CARE UNIT GOES ON HOLIDAYS Julie Rowse Holidays are an experience the general community take for granted. They are an opportunity to have a good time, relax, and have lots of fun. But for someone in an extended care unit holidays are but a dream, a figment of one's imagination. Sovereign House extended care unit dared to make dreams become a reality. For the third year running the twelve residents of Sovereign House and the staff ventured to the beach for a three night holiday. Prior to leaving on the holiday a literature review was completed. From this it was discovered little had been written about people with long-term mental illness going on holidays, particularly those in an extended care unit. This paper was designed to contribute valuable information on the benefits of holidays with this population. The holiday was evaluated in three ways, the use of PRN medication on the holiday compared with at the unit, client satisfaction survey, and a staff report survey. The results showed that the number of PRN medication used on the holiday was not significantly different to when at the unit which suggests that a holiday for an extended care unit is quite viable. The clients satisfaction survey found that ten of the eleven clients who completed the survey enjoyed the holiday. The staff reported they also enjoyed the holiday and the benefits to the clients included a less restrictive environment, one to one staff contact, freedom and choice around how clients spend their day, physical, psychological and social benefits, opportunities to relax, and above all having a good time and experiencing new things. Overall, this paper demonstrates that it is possible to take an extended care unit away for a holiday and it is not only a successful and enjoyable experience, but one that is beneficial for the wellbeing of the clients.

29 Paper: THE DEVELOPMENT OF COMMUNITY PSYCHIATRIC SERVICES IN WESTERN AUSTRALIA. Terry Buchan Like community based services elsewhere in the world, development in WA has been erratic and beset by "wicked" problems. Some of these problems are similar to those experienced in the UK and could have been foreseen; others have arisen unpredictably during development. Predictable problems arose in the UK from each of the four planks of Enoch Powell's Hospital Plan: The gradual run down of the mental hospitals The establishment of acute psychiatric units in general hospitals The provision of day hospitals and hostels The provision of

a substantial increase in medical and ancillary workers These events were mirrored by a number of developments in WA. The following list of attempted solutions is by no means comprehensive but includes some processes with which the author had some personal acquaintance and involvement: The progressive reduction of beds in Claremont, then Graylands Hospital and the closure of Heathcote Hospital The establishment of acute units at Fremantle and Bentley Hospital The development of the Hostel programme in Swan District Attempts to increase medical manpower by: involving general practitioners in the care of the mentally ill in Swan and Fremantle catchment areas by developing training programmes and consultation liaison services, and exploring some possible options for a diagnostic system suitable for primary care improving undergraduate and registrar training Some of the unpredictable problems that have emerged include: The political pressures to which the developmental processes have been subjected The emergence of dual diagnosis and homelessness as significant clinical factors The lack of a theoretical underpinning for community psychiatry The consequent difficulties in setting clinical boundaries and the emergence of multiple models Difficulties in relationships with non - governmental organisations and consumers Work on these problems is ongoing.

30 Paper: PSYCHOEDUCATION INNOVATIONS IN ACUTE CARE SETTINGS Tim Coombs, Maree Vukovic The dream of providing comprehensive and individually tailored psychoeducation meets the reality of increasing demands on acute community and inpatient services. Administrators need evidence of service delivery. Staff say "I want to, but I don't have the time", while consumers and carers are left to gain information in an ad hoc and harried fashion. At the completion of this paper, participants will be able to describe the approach being used in acute inpatient and community settings in the Illawarra to overcome these tensions. The authors will demonstrate a program that not only provides evidence of psychoeducation but also develops staff skills and delivers individualised psychoeducation to consumers and their carers. Utilising psychoeducation material from EPPIC, the authors manipulated and condensed the material provided into a series of brochures. The advantages of this format are immediately obvious. Staff are able to provide consistent information to consumers and cares in either group or individual settings. Staff skills in sharing information are developed with the brochures becoming a tool that focuses on engaging consumers in a way that personalises the information given, preventing brochures from simply becoming "another piece of paper". The brochures combine to provide a comprehensive psychoeducation program that covers recognition, aetiology, medication, drug and alcohol use and support during recovery from psychosis, as well as providing information on services within the local area. In this way, the program can be seen as the start, not the end, of a process. The information provides consumers and carers with a foundation from which to seek help and engage with longer-term care.

31 Paper: DISSOCIATION: IT'S ROLE IN PTSD AND HYPNOTHERAPEUTIC INTERVENTION Christine Ffrench, Francesca Collins DSM-IV describes dissociation as the process whereby the usually integrated functions of consciousness, memory, identity, or perception of the environment are interrupted. Dissociative experiences are characterised by compartmentalisation of consciousness, that is, certain mental events that are ordinarily processed together (eg. thoughts, emotions, sensations, memories and attitudes) are isolated from one another and rendered inaccessible to consciousness and/or voluntary recall. The connection between the development of dissociative symptoms and personal traumatic experiences has been well established in the literature. Transient dissociative reactions have been linked with the experience of life threatening trauma, as typified in ASD/PTSD. It has been suggested that in such cases, dissociation is an adaptive, defensive function which enables the individual to survive what would otherwise be an overwhelming trauma. Hypnosis is another state in which dissociation is experienced, incorporating the phenomena of absorption and imaginative involvement. The induction of a trance state utilises those phenomena as part of the therapeutic process. It has been found that people suffering from PTSD rate highly on measures of hypnotisability, although it is not clear whether those who dissociate easily tend to suffer from PTSD following trauma, or whether the experience of trauma enhances the ability to dissociate, and hence hypnotisability. Regardless of which comes first, it makes sense to utilise that capacity to dissociate within the therapeutic context, making hypnosis a useful therapeutic tool when dealing with ASD/PTSD. It is the aim of this paper to explore the links between the three phenomena, dissociation, PTSD, and hypnosis, and to give examples of the use of hypnosis in the treatment of PTSD.

32 Paper: DREAMING REALITY AND THE COERCION OF SELVES Malcolm Morgan
This paper explores the consequences that accompany portraying "Reality" and "Dreaming" as oppositional concepts. In the conventional model of this portrayal Reality is viewed as the fully credentialed world view, whilst Dreaming is entirely insubstantial, and has no place in the waking world of reality. Within the terms of this oppositional structure Reality may be augmented and enriched by Dreaming, but Dreaming, outside the constraints imposed by Reality, is a form of madness. The internal logic of this oppositional system, asserts that, for good or ill, Reality exists, and that, notwithstanding their allure and evocative power, Dreams do not. The best that Dreaming can claim within this descriptive model is as a modifier of Reality, usually in the form of an escape from the harshness of what is coercively claimed as Real. The paper discusses the sorts of Selves that are possible within this tightly regulated oppositional system, where convention becomes the

arbiter of sanity, and those who live too fully within a Dreaming world are at risk of being labelled mad. The paper explores other, more promising ways of talking about the relationship between Dreaming and Reality, which open up different possibilities. The works of Christopher Bollas and Adam Phillips are discussed, and the idea introduced that Dreaming may be a useful and powerful metaphor for describing our sleeping and waking lives. Dreaming Reality affirms multiple versions of the world of human experience, obviating the need to assert the primacy of one version, which triumphs over all others, in the name of Reality.

33 Paper: WHOSE DREAMS? WHOSE REALITIES*?* **Elizabeth Kolaitis** AIM: To provide insight into the GROW organisation and how it enables people to tap into and make use of their personal resources. CONTENT: Before I was a twinkle in my father's eye or a smile on my mother's lovely face, on the other side of the world in a land "down under" – a place Dorathea McKellar wrote of as being "a sunburnt country, a land of sweeping plains, of rugged mountain ranges of drought and flooding rains, a land of far horizons, a land of jewelled seas, of beauty and of splendour – a wide, brown land". On the 26th April 1957 in Hurstville, a suburb of Sydney, a dream was being realised by a group of people as diverse and interesting as the land they inhabited. Brief profile on co-founders of GROW. At the core of their vision was How to get mental health How to keep it Understand how it can be lost How to transform themselves from mentally ill patients into healthy persons and leaders for mental health in the community for others like their former selves. Explain how the GROW Program evolved the Group Method was created out of a need for more than a tea and sympathy group Expand on what happens in a GROW group how through the tools of the Program and the Method, people are enabled to realise their value, their potential, ability to make goals and strive to attain them. Highlight the importance of self-activation, leadership, friendship and community and the role they play in attaining/regaining mental health and well being – making dreams into realities. Explain the importance of collaborative effort/partnerships for achieving health between individuals, GROW, professionals and other supports and agencies.

34 Paper: MOVING BEYOND LOCKED CABINETS : THE JOURNEY OF THE LOGAN CONSUMER AND CARER ADVISORY GROUP FROM OTHERS' DREAMS TO OUR OWN REALITY Diane Pope, Diana East
For a Consumer Advisory Group (CAG) to be a place of empowerment for its members, and to function healthily and address real issues, it's structure and processes must foster freedom and enablement. The ways in which we structure CAGs and perceive power determine what can happen in that group, how conflicts can be resolved and how creative energies can be manifested. CAGs can either be places of strength or places of frustration and disempowerment. Power means to "be able"; in order to become able CAG members need a supportive, enabling environment.This paper utilises the experiences of the Logan CAG and its relationship with the Mental Health Community Development Officer (MHCDO) in the Logan area to explore issues of group structure, enablement and developmental processes. The CAG's journey is described within an innovative framework which uses the elements of air, fire, water and earth to describe the different stages of the group's journey. The "air" stage covered the early days when the attaining of locked cabinets for hospital patients was seen by the Mental Health Service as exemplifying real achievement; in establishing a common vision/set of ideas group members began to ask "whose vision/ideas are we developing?". During the "fire" stage the group began to experience power struggles and acknowledged the need to address group dynamics so that members were validated and empowered. The "water" stage covered a time of much reflection and review and led to combining with a group of carers in order to renew sources of strength; it was a time of emotion, nurturing, developing trust and replenishing energies. Now the group has reached the "earth" stage and real change is beginning to happen as members tackle real issues which are related both to their identification as individual consumers as well as to "bigger picture" issues. One of the objectives of Queensland's Mental Health Community Development Strategy has been to enhance consumer and carer participation in service planning, operation and evaluation through supporting and strengthening local CAGs. Using community development and social justice principles the Logan MHCDO has consistently worked in partnership with Logan CAG members to assist their development and real participation with the local MH Service. The presentation of this paper will model the way the CAG and the CDO have consistently talked, listened, reflected, worked and grown together. It will include a clip from a video made by the CAG members.

106 Paper: ENGAGING THE LONG TERM MENTALLY ILL USING INTEGRATED MENTAL HEALTH
Jacet Donaldson , Jennifer Pierens Historically, the treatment of mental illness has been that of institutionalisation, resulting in the de-emphasisation of the importance of family/ carer role and significant others (i.e. General Practitioner and Health Care Providers) which has contributed to some clients reluctance to engage in treatment. Over recent years, we are seeing less institutionalised treatment and a greater focus on family/ carer/ primary health carer provider

involvement, which is the foundation of Integrated Mental Health Care (IMHC), resulting in engagement and better outcomes for those with enduring illness. In a practical sense, the structure of the Warrnambool and District Base Hospital Psychiatric Services Divisions allows for continuity of treatment by the same Clinical Therapist through the various phases (i.e. Crisis Intervention, pre and post admission, and ongoing community treatment), which assists in the engagement of long term clients and their family/carers in treatment. This paper outlines the advantages of working closely with families in the context of Integrated Mental Health Care and the continuity of care to engage Long Term Mentally Ill.

107 Paper SUPERVISION. MAKING THE DIFFERENCE IN CLINICAL PRACTICE. Philip Hose, Samantha Splatt Do initials after a person's name necessarily equate with proficiency? Is there a difference between those trained twenty years ago and those more recently? What is the responsibility of the service, in terms of quality assurance, to its staff? Does paying registration fees equate with competent clinical skill? Clients, families and the community at large reasonably expect qualified professional staff in mental health services. Indeed it is the requirement of most employers that their staff are formally qualified. The Warrnambool and District Base Hospital (WDBH) has a multi-disciplinary team focus encompassing a range of disciplines. This enables the hospital to not only draw on a range of knowledge and experience, but the opportunity for clients and staff to mutually benefit from a range of specialist skills. Some of us may look back and cringe at the skills and preparedness our training equips us with. Whilst our theoretical backgrounds may stand us in good stead, the practical application may leave much to be desired.We would argue that it is the in-vivo development that sets apart the quality clinician from the merely adequate. Whilst we bear the responsibility for the maintenance of our unique discipline with review of recent research, developing trends and further training, there is a important and major role for consultation and supervision with experienced staff and/or colleagues. The value of Supervision is recognised by many clinicians as a valuable form of staff professional development and many services provide the opportunity for this to occur. This paper seeks to explore further the benefits of supervision, but also to emphasise some different approaches to its implementation.

108 Paper: ORGANISATIONAL CHANGE: MAKING THE REALITY ACCOMMODATE THE DREAM Glen Tobias, Arthur Papakotsias Introduction The age of economic rationalism has brought with it a tidal wave of down sizing, out sourcing, CCT etc and a great deal of pain has been felt by workers and managers who found themselves caught up in these processes. Lately when the term organisational change is mentioned many people have an immediate negative reaction as it has come to mean "getting done over ".It is in this context that Neami considered an organisational re-structure and how it might be possible without it turning into a disaster for all concerned. In this case, consideration of an organisational change was partly driven by a need to position the organisation to enable it to accommodate future growth, but mainly by a desire to ensure that the structure of the organisation supported its function which in turn maximised outcomes for clients. Methodology The starting point of the process was a number of hypotheses made in order to provoke discussion and reflection amongst staff on whether the service was as good as we hoped for and whether structural changes might enable functional change that benefited clients. Staff and Committee of Management were involved in a number of forums where various models were developed and discussed before the organisation as a whole met in an attempt to reach a decision .Results Regionalisation & Multi- tasking A commitment to change was reached involving a management restructure, a change of workplace for some staff and changes of job descriptions and duties for all staff. Conclusion Restructuring doesn't have to be a road to hell but there are a lot of anxieties, pressures and expectations that need to be carefully managed to avoid being hijacked down that all too common route.

109 Paper: VOLUNTEERING PEER SUPPORT Denise McAtee, Sherrill Meredith This paper aims to reframe volunteering in terms of peer and mutual support. Breakaway Visitor Service is an in-home respite service provided by SFV and Outdoors Inc.. The service provides a mixture of staff provided service for short-term and occasion limited respite and volunteer visitors for longer-term regular respite. For a vast number of people having a volunteer visitor is the option of choice. There are many and varied reasons for this choice. In essence many of these reasons amount to the desire for peer support. Whom one views as one's peers is an individual perspective. For a 20-year-old person recently diagnosed with schizophrenia, their strongest view of a peer group may well be other 20-year-olds. The background and experience of our visitors is varied and includes 15% consumers and a further 21% who have been affected through a relative or friend having a mental illness. Visitor matches vary in their level of 'peerdom'. Interviews have been conducted with the people involved in visitor matches. Matches have been selected to cover the different levels of 'peerdom'. The aim of the interviews has been to identify the nature of the distinctive attributes of these matches, the distinctive outcomes for both people in the visitor match, and how these attributes and outcomes vary across the different levels of 'peerdom'.

110 Paper: A MODEL OF CARE FOR WOMEN WITH POSTNATAL DEPRESSION Marion Stein, Jose Menendez, Vanessa Postnatal Depression (PND) is a psychiatric disorder that affects 10-15% of women within the first six months postpartum. However, it is often undiagnosed and untreated. The NSW Health Department has highlighted the need for prioritisation, identification and education of PND, with skilled and experienced professionals and appropriately resources services. The numerous demands placed upon the limited resources of contemporary mental health services often leads to provision of erratic services to women with postnatal depression. The current research outlines an innovative stepped care program developed within the Macarthur Sector of the South Western

Sydney Area Health Service. The program consists of two stages of service delivery. The first stage, provided to all women, consists of an 8-week manualised, semi-structured group program, the main theme being "How to Manage My PND Better". The 2-hour sessions cover education, skills development, normalisation of feelings, cognitive work about self, motherhood, negative thinking and subsequent feelings and behaviour. Self-care is of paramount importance and is continually emphasised throughout the program. One evening for partners is included. The second stage, restricted to those displaying more severe depressive symptoms or with additional psychosocial stressors, consists of intensive case management and psychiatric contact. Case management involves regular home visiting for: a) monitoring of the woman's mental state, b) involving supportive services for practical help in the home, c)liaising with the woman's clinic nurse for baby's needs, d) offering support to partner and family members, e) assessing risk to mother and baby, f) monitoring medication prescribed, g) providing educational material, and h) offering supportive counselling and normalising of feelings. Psychiatrist's reviews are also part of this stage.The program is now being assessed for its benefit to women on a number of levels. Women with PND often exhibit symptoms of low self-esteem, anxiety and less enjoyment in their lives; this in turn affects their relationships; thus, the Macarthur Service is now trying to assess whether the program causes significant positive improvements in these areas. Some promising preliminary results have been collected, as well as encouraging comments from the women themselves.By adopting a stepped care model of service delivery, the Macarthur Sector of the South Western Sydney Area Health Service is able to provide intensive service delivery to mother who are greatly incapacitated by their postnatal depression while maintaining cost effective services to other mothers with evidence of postnatal depression who might otherwise be excluded from service delivery. The stepped care approach provides an effective and efficient model, allowing a service to maintain a commitment to high level clinical outcomes while maximising a limited healthcare dollar.

111A Paper: NON-GOVERNMENT ORGANISATIONS PROVIDING MENTAL HEALTH SERVICES - IS THEIR "REALITY" Different? Rob Warriner Over the last 10 years in particular, the role of Non-Government Organisations (NGOs) as providers of mental health services has grown significantly. We now refer to the NGO "sector"; this sector is becoming acknowledged as having a key and increasingly fundamental role in the provision of mental health services. Such acknowledgement is a long way away from the not too distant past where such organisations and groups were regarded as well-meaning volunteers who might have an important but limited role in assisting mental health professionals in supporting "released psychiatric patients" in the community.My own background in the mental health "industry" has been solely informed by work in the and development and growth of an NGO in Auckland, as well as through initiatives to develop national associations and to represent an "NGO voice" at various forums. However, these latter initiatives have caused me to reflect upon what it is I am being asked to represent? Whose/what interests am I up-holding?Is the notion of an "NGO sector" a premature assumption? Is there a group of like-organisations with sufficient shared interests, values, philosophy and history to warrant our referring to ourselves as a "sector"? What do they stand for? This paper illustrates / discusses the roles and qualities of NGOs in their development and delivery of mental health services, suggesting what may be the unique, invaluable qualities of such organisations. Finally the paper looks at the challenges and opportunities which NGOs can / will need to address to successfully continue their dynamic development.

111B Paper: MYTHS, REALITIES AND DREAMS OF COMMUNITY BASED MENTAL HEALTH SERVICES Rob Warriner a myth is "...a form of communication, that can't be taken quite literally, but that gets it's public credence and support from it's capacity to express in relatively simple terms, relations between ideas and events that aren't completely understood, and whose outcomes can't be fully foreseen". (Dr. C. Beeby, former Director-General Education, 1985) The above definition was originally used in the context of education in New Zealand. However, its utility in describing the development of community based mental health services appears just as pertinent, and is a central theme of this paper. This paper makes an assumption that if the process of deinstitutionalisation of mental health services is to be successful, then the kinds of changes demanded actually constitute a revolution in the conceptualising, development and delivery of mental health services. Is this revolution occurring? While notions such as empowerment, choice, integration, and recovery have been adopted as the current parlance within mental health services, a clear understanding of these and their implications for service delivery, remain essentially at a conceptual level. In my years in mental health, I have yet to meet someone who does not support these ideals. They ostensibly enjoy almost universal support and acceptance. So why do people who receive our quality services still consistently feel dis-empowered, with little choice, few opportunities for integration, and trapped without hope? Who or what is holding up the revolution? So, (in the spirit of revolution!) and informed by my visit to Trieste, Italy last year, this paper sets out to be deliberately provocative in highlighting some of the myths, and the realities, from a perspective that challenges the ideologies, values and philosophies of mental health service delivery.

112 Workshop: BEAR IN MIND:THE HEALTH AND WELL-BEING OF PEOPLE WITH ACQUIRED BRAIN INJURY Ria Strong Many people with acquired brain injury struggle with mental health difficulties, as well as with physical and/or cognitive impairments. For some people, acquired brain injury and psychiatric disability co-exist coincidentally. For others, brain injury itself causes mental health problems-by damage to the parts of the brain regulating emotion, for example. Most commonly, however, the mental health problems experienced by those of us with acquired brain injury result from psychosocial consequences of such an injury. Loss and grief reactions are almost

universally experienced, and clear-cut depression is very common. Bear in Mind is a self-advocacy group for people with acquired brain injury; several members of the group are also past or present consumers of mental health and/or psychiatric disability support services. Community education is a key aim of Bear in Mind; those of us in the group want to dispel myths about acquired brain injury, raise community awareness and change community attitudes. Using a self-advocacy presenters' kit developed by people with ABI, we provide training for both professional and community groups. Bear in Mind presentations focus on the psychosocial aspects of living with acquired brain injury-including depression and adjustment to loss, changes in relationships and friendships, social support, communication issues and self-esteem. At THEMHS, we intend to cover these issues in an interactive workshop-using innovative experiential activities, graphics and personal stories to increase understanding of the particular challenges those of us with ABI face.

113 Poster: BEAR IN MIND:MAKING PUBLIC THE CHALLENGES EXPERIENCED BY PEOPLE LIVING WITH ACQUIRED BRAIN INJURY Lea Kewish, John Wakefield, Sheridan Campbell, Ria Strong Bear in Mind is a self-advocacy and community education group for people with acquired brain injury. The group's presentations focus on the psychosocial aspects of acquired brain injury-including depression and adjustment to loss, changes in relationships and friendships, social support, communication issues and self-esteem. Bear in Mind developed out of the Health and Wellbeing of People with Acquired Brain Injury project, completed by the Centre for Social Health. In this project, people with acquired brain injury identified, in group activities, issues which impacted upon their successful re-integration into the community. One issue identified was poor community knowledge and understanding of acquired brain injury, as distinct from intellectual disability or psychiatric impairment. These initial project participants wanted to dispel myths about acquired brain injury and present their experiences and perspectives to the public. As part of their group work, they explored personal issues, practiced presentation skills and devised support materials. These were then used to develop a presenters' self-advocacy kit, now used by Bear in Mind members to educate community groups and health care professionals about issues related to living with acquired brain injury. The quality of the presentations and the personal stories the speakers share with their audiences are a testament to their courage and determination. The Bear in Mind speakers make professionals and non-professionals alike question their assumptions about people with acquired brain injury; they remind all who hear them about the importance of genuinely listening to people, and respecting them as individuals. The Bear in Mind poster introduces some of the speakers from the group, outlines the issues discussed in the public education program, clarifies for whom the presentation is suitable and gives information for contacting the Bear in Mind group.

114 Paper: HOMELESSNESS, MENTAL HEALTH AND TRAINING SUPPORTED ACCOMMODATION WORKERS Moira Deslandes, Sandra Miller This short presentation will tell some of the highlights of three and a half years of designing, developing and delivering training to workers funded by the Supported Accommodation Assistance Program. SAAP workers were trained by consumers, carers and staff from *Social Options Australia* in metropolitan and rural centres. The training is an accredited 24 hour module. This presentation will include excerpts from a video made by carers and consumers in consultation with Social Options Australia and SAAP workers about what people with a mental illness who are homeless or at risk of being homeless should know. The video is called Helping Us Help You. Evidence will be shown on how the level of confidence grew in workers as a direct of result of the training for their work with consumers with mental health workers. Additional evidence will include statements from workers about their experience of learning from young people who are the children of people with a mental health concern. The paper will identify issues for training in mental health and introduce some resources and techniques which can be easily applied and translated to a range of settings. The paper will draw together the key learning from the training and what can be passed on to other workers, carers and consumers.

115 Paper: THE IMPACT OF WORKSHOPS, PRESENTED BY A CONSUMER/PROVIDER ABOUT SELF ABUSE AND ITS TREATMENT, ON PROVIDER ATTITUDES TO WORKING WITH PEOPLE WHO DELIBERATELY SELF-HARM Sue Fitchett, Roy Krawitz, Mary Graham Mary Graham co-founder of SAFE Canada (SELF ABUSE FINALLY ENDS) was seconded to RREAL; Waitemata Health; Auckland, New Zealand during the first three months of 1999. During her contracted time Mary ran her FOSTERING HOPE workshops on self abuse and its treatment, for clinical providers who work in mental health services. In consultation with an independent research partnership (Research Works New Zealand Ltd), an evaluation was designed to quantitatively and qualitatively measure changes in provider attitudes to working with people who deliberately self harm. This paper presents the results of this evaluation. Three quarters of the participants in the workshops consented to be part of the evaluation project and filled in a pre and post workshop questionnaire. The independent researchers also interviewed a random selection of these participants. Positive change in provider attitudes towards working with people, who deliberately self harm, occurred on a number of variables. There was also a trend to positive change in the variable, 'sense of competence' in working with people who self-harm, which is seen as a pre-cursor to other attitude changes. Other variables that showed positive change included; 'willingness to work with"; 'sense of effectiveness'; 'positive feelings towards people who self-harm'; 'willingness to continue to work with people who self-harm. Amongst qualitative measures there was increased belief in the importance of honesty with the client, clients taking more responsibility, collaboration with the client and empathy and listening. There was some decreased belief in setting

boundaries and clear and consistent communication. These latter unexpected/unwanted changes were followed up during the qualitative interview. This paper will present some data on this and suggested changes to the workshop presentation, as will as some discussion about the issue of the 'risk taking environment', in relation to working effectively with people who deliberately self harm.

116 Paper: POSTCARD FROM ABROAD: DREAMS & REALITIES FROM THE PERSPECTIVE OF THE QUEENSLAND NESB COMMUNITY Katie Andronicus, Lucia Reguera The Queensland NESB CAG was formed in December 1996 following a public forum in Brisbane attended by a range of consumers, carers, service providers and members of various ethnic communities. The forum provided evidence that NESB people with mental health issues faced many hurdles when seeking and obtaining assistance from mental health services. These difficulties were compounded by the fact that Queensland is relatively sparsely populated across huge distances. The needs of NESB consumers and carers had been recognised by the Queensland Transcultural Mental Health Center which began in December 1995 and with the formation of the NESB CAG a partnership was formed to work together to transform dreams into reality. Reality is different for every individual, and culture is only one of the variables which influence the way in which a person views reality. A challenge for the NESB CAG has been to develop mechanisms which can appropriately unearth the realities as viewed by people from various cultures and ethnicities. This challenge is made more difficult through language barriers which can only partly be remedied through the use of interpreters. These challenges are being overcome through the utilisation of an informal approach, which doesn't emphasise the immediate need for group structure, but rather focuses in the early development phase of the group on rapport building and taking time to understand the realities as viewed by various members of the group. This paper explores the challenges faced by Queensland NESB consumers and carers, and the successes they have achieved over the past two and a half years in the pursuit of their dreams.

117 Paper: DEPRESSION AND SUICIDAL IDEATION FOLLOWING ABI. John Wakefield Depression and suicidal ideation are common sequels to a traumatic brain injury. This paper outlines the personal experience of a person with Acquired Brain Injury some time down the track after formal rehabilitation has been completed. The paper examins some of the techniques of cognitive therapies and suggests some home grown techniques that were found to be effective. The value of self advocacy support groups is discussed in particularly the activities of the Bear In Mind group in Melbourne. Extetonl ist theology is used as a metaphor for human disability services examining the notion of " I am therefore I am" in the context of a person with an acquired disability. Martin Seligman's notion of attribution style are described together with skills that can be taught to change ones habitual explanations and develop a more optimistic thinking style. The barriers to a personal happiness descibed by Albert Ellis are discussed including special barriers adapted to the feeling states of a person with a disability. The attempts of a person with a disability to redefine his identity in spite of the messages and the culture communicated by the human service system and the importance of self advocacy support groups are discussed.

118 Workshop: USING INTERACTIVE FACILITATION TECHNIQUES TO PROMOTE ATTITUDE AND BEHAVIOUR CHANGES IN THE 'CAMPAIGN TO COUNTER STIGMA AND DISCRIMINATION ASSOCIATED WITH MENTAL ILLNESS Debbie Hager, Roine Lealaiauloto., Angeline Hekau, Marty Rogers, Robert Skipwith -Te Hapai Te Hauora Tapui, Alison Taylor, Peter O'Conner The 'Project to counter stigma and discrimination associated with mental illness'- A partnership between four providers in Auckland, New Zealand. Aims. To outline the division of responsibilities of the providers and the process for working together to cover the needs of the diverse Auckland population. To precis the unique direction taken by each organisation to meet the needs of their specific target populations Framework Trust, Pacificare, Te Hapai te Hauora Tapui and the Mental Health Foundation are involved in the Auckland regional component of the "Project to counter stigma and discrimination associated with mental illness' This project has a number of specific target groups to be reached, divided by ethnicity and by purpose. Four organisations, one Maori, one Pacific Nation and two mainstream, deliver outcomes related to workforce development, policy development, curriculum development, families, consumers and the community. Each organisation has developed their own structure and 'flavour' to encourage buy in and participation in their programmes.This workshop will enable participants to have a taste of each of these approaches, related to one of the outcome measures and to discuss why the organisation choose to work in the way that it is. There will also be discussion about how this diversity works within an agreed framework of "Everyone has a valued place in society" and how the project aims to change attitudes and behaviours in the region.

119 Paper: THE CHALLENGE OF DRAWING ON STRENGTHS IN A RURAL COMMUNITY Brian Thomas Rural communities have their own unique characteristics. These are varied in each setting. The dynamics of the situation, as a result of being isolated from services enjoyed by a larger populace, require the people of rural communities to look more closely at the local community resources available to them. Our aim in this paper is to outline the events that have occurred during four years and three months of providing and receiving Mental Health support in two rural communities of Otago N.Z. We will explore the following: The Stigma that was initially faced and continues to exist. Resourcefulness of both staff and clients, "going that extra mile for each other", and also the wearing many hats to enable a project to work. The boundaries often tested to a larger extent than in a city environment. The prejudices and labels that result from clients "other baggage" being known by the wider community. The scarcity of services for both staff and clients. Invasion of privacy with an "everyone knows everyone else's

business" syndrome. For good service to be delivered we need a commitment to go the whole way. Employment opportunities for clients are important as is the support and input of family members and networking with related services. We plan on sharing the personal experiences of families, clients, staff and other service providers, in the two communities, to clearly outline the rural experience of these Otago townships.

120 Workshop: SUSPICIOUS MINDS "DEVELOPING A MODEL OF COLLABORATION FOR CONSUMERS, PUBLIC SERVICE AND NGOS Iwona glowinski Bill Hofmeyer, Kate Thomas, Gise Paine
WITH deinstitutionalisation we have seen the emergence of mental health services provided through n on-government agencies. This shift in services has at times resulted in a climate where the stake holders: mental health services consumers, Key Workers and non-government support services have viewed each other suspiciously. The aim of this workshop is to facilitate an open discussion in regard to this. What has worked and what has not in the partnership between these three parties will be some of the questions the presenters will ask themselves. The audience will be invited to contribute their experiences of developing an effective partnership. Participants of the workshop will be encouraged to contribute their thinking in developing a collaborative model of working between Consumers, Key Workers and NGOs with a view of providing the best outcomes for consumers. There has been a move to tender out non-clinical services such as community living support that included housing, in home support services, employment, community participation and recreation, to non-government agencies. Port Adelaide Central Mission in South Australia has successfully tendered for a number of different projects that assist people with mental health care needs. Having managed these projects between two and three years we have made some observations of how this shift to non-government service delivery impacted on consumers, Mental Health Services and ourselves. The workshop presenters will be representative of the above parties and will include: a mental health services consumer, coordinators of three different NGO projects and team leaders from two different MHS regional offices in Adelaide. The three projects have the same clientele but offer different services. They also have different degrees of autonomy from the Mental Health Services. Pros and cons of these arrangements will be analysed at the workshop. It will be suggested that any model of collaboration should be flexible enough to consider differences between projects .It is expected that at the end of the session a model of collaboration will be developed. It will be circulated to workshop participants for comments soon after the conference and a final version distributed upon receiving those.

121 Paper: TE KOROWAI ATAWHAI SPECIALIST MAORI MENTAL HEALTH SERVICE Lynne Pere, Ruahine Crofts, Tahi Takao, Erihana Ryan Te Korowai Atawhai has been developing as a Specialist Maori Mental Health Service within the Mental Health Division of Healthlink South Limited, the largest mental health provider in New Zealand, for about seven years now. The foundation of Te Korowai Atawhai are our Kaumatua and Taua (elders) who provide essential cultural wisdom and guidance, ensuring accountability to Maori. The Kaumatua alongside Te Ahorangi (Clinical Director), Te Kaiwhakahaere (Unit Manager) and Te Kaiatawhai (Service Manager) also form the Maori Health Executive, Te Kahui Pou Hauora Maori.Our aim as a Service is to improve the delivery and quality of health services to tangata whaiora (Maori consumers of mental health services) and we do this primarily through the mahi of 11 Pukenga Atawhai (Maori Mental Health Workers) employed in a number of multidisciplinary clinical teams. The philosophy of our Service is Whanaungatanga- a concept which not only acknowledges that our work is not done in isolation but as a member of a whanau; whanaungatanga also acknowledges the importance of tangata whaiora being members of a whanau and as such merely being the symptom carriers for their whanau. In our presentation we will be speaking about whakawhanaungatanga as a healing programme.

122 Paper: TE ORANGA O TE TANGATA HEALING PROGRAMME Wendi Crofts and whanau Arohanui is a programme that has been developed by Maori for tangata whaiora (Maori consumers of mental health services) at Healthlink South Limited, the largest mental health provider in New Zealand.Arohanui has been developing over two years as a programme that uses waiata and whanaungatanga to provide healing and wellness for tangata whaiora. This programme incorporates a Maori holistic approach to health, encompassing concepts relevant to the wellbeing of the individual, whanau, hapu and iwi. The use of music in therapy is well documented. For tangata whenua, the benefits from using waiata not only include helping settle everyone to a common level, but used as a tool also help whanau remember and relate to geneology. Waiata incorporates power of positivity through the use of assertive words and creates an enviroment which is conducive to healing, wellness and growth. Also essential to the programme is the concept and use of Whakapapa, which is an acknowledgement of who we are, where we have come from, our geneology, our tribal links, and where we have our foothold on a place that belongs to us as of right. Identity plays an important role in a person's sense of belonging and it is within this context that a commonality is found, linking kinship. In this presentation, we will present Arohanui as a healing

123 Paper: GENERAL PRACTICE UTILISATION IN SHARED CARE Katherine Nelson, Debbie Peterson
This paper reports on the use of general practice by a cohort of people with on-going mental health needs who were involved in a shared care pilot. This pilot enabled people to see their general practitioner free-of-charge. The paper reports on how utilisation changed over a two year period. In addition to looking at rates of utilisation the paper also reports on details of the consultations, namely i) who the consultations were with (consumer, family or both); ii) the type of consultation (routine or acute); iii) the place of the consultation (phone, surgery, home or after-hours); iv) the reason for the consultation (psychiatric, general medical or social); v) the outcome of the consultation (support, medication, liaison etc); and vi) the length of the consultation.

124 Paper: OPTIONS AND ISSUES WHEN MENTAL HEALTH SERVICES PAY GPS TO PROVIDE CARE
Katherine Nelson This paper initially discusses the funding options that arise out of recent developments in New Zealand that involve general practitioners being paid additional government payment to provide a service for people with on-going needs for mental health. In particular it looks at the implications of fee-for-service and capitation payment methods and the implications of having the payment follow the patient, the general practitioner or the general practice. The paper then looks at the issues that need to be addressed to enable a sustainable model of paying general practitioners to be developed and discusses whether targeting people with on-going mental health needs in a general practice setting contributes to the recovery model.

125 Workshop: MOOD, ACTIVITY AND THINKING – A MODEL FOR EDUCATION ABOUT OVERCOMING NEGATIVE EFFECTS OF MOOD DISORDERS. Madeleine Kelly, Robyn Souter During the workshop, a paper outlining the Mood, Activity and Thinking model for mood disorder education will be presented. Participants (which may include consumers, carers and clinicians) will have the opportunity to interactively experience the application of the model to their own circumstances. The paper, which will be made available to participants during the workshop, is based on both a theoretical psychiatric framework and consumers' experiences of mood disorders. We present an accessible, diagrammatic approach to understanding mood disorders from both perspectives. This series of diagrams illustrates the classification of mood disorders including mixed states, the action of psychotropic medicines used in mood disorders, and practical means by which consumers, carers and clinicians can identify individuals' early warning signs and major alerts. The paper demonstrates how to identify agreed concrete, behavioural measures that validly and reliably indicate the onset or acceleration of the illness process. The paper demonstrates how consumers, carers and clinicians can use early warning signs and major alerts to limit damage and obtain appropriate assistance – 'Safety Nets' and 'Brakes'. The paper concludes with an exploration of ways of distinguishing symptoms from normal responses to life events – 'How to tell if you're sick or just having a bad hair day'. The paper will be followed by interactive work in small groups (mixed as to consumer, carer and clincian roles) to illustrate how the model can be applied by consumers, in the relationship between consumers and carers, and by clinicians. The interactive work will be supported by pre-printed worksheets on which participants can enter individual behaviours that constitute valid, reliable subjective and objective early warning signs and major alerts, record agreed strategies in response and list their own 'Bad Hair Day Identifiers'.

127 Paper: TE ATA – FORMING PATHWAYS THROUGH PARTNERSHIP Leanne Catchpole, Mark Spriggs
In West Auckland, New Zealand a consumer led working party, facilitated by an Occupational Therapist was established to develop a community based mental health support centre. This collaborative approach was in response to an expressed need from consumers, family and health professionals for such a centre. This paper has been prepared and will be presented by the Project Co-ordinator and a consumer representative from the working party. We will outline the process we went through over the 1 1/2 year period that it took to establish the centre and illustrate the many tensions and successes that emerged. The working party consisted of 2 O.Ts and 8 consumers, none of whom had all of the skills or experience required to set-up such a centre. Through a collaborative partnership approach the consumers were able to participate effectively in the process. Along the way they gained the skills and confidence to form a trust and put a proposal to the Regional Health Authority for funding. The funding that we received was not enough to establish a centre of quality, so a joint venture partnership was formed with Waitemata Health employing the staff for the centre.We will talk about how the process affected us personally and challenge the notion that consumer run services need to be exclusively independent. Through telling our story of the establishment of our centre we will demonstrate that professionals and consumers can work together to facilitate and assist consumers to establish their own services. Once established Mental Health services can continue to work in partnership, with the 'power' remaining with the consumer group running the service. A working party member who said "We couldn't have done it without Waitemata Health and they couldn't have done it without us" best summed up this collaborative approach.

128 Paper: WHOSE DREAMS? WHOSE REALITIES? GENDER AND PSYCHOSOCIAL REHABILITATION. Janet Spink, A Report on the Different Perspectives of Users, Providers and Policy MakersIn recent Ph.D research the presenter investigated the gendered use of psychosocial rehabilitation services by men and women who were labelled with a psychiatric disability. This paper will explore the results of the question asked, "why women attend psychosocial day programs less frequently than men. Using semi-structured interviews the presenter interviewed 64 service users, 30 service providers and 12 policy makers, half of whom were women and half of whom were men. A feminist gender analysis was created, revealing that: trends of difference were difficult to find and only around certain issues or processes; day programs were gendered, providing services to more men than women based on age, ethnicity and class; policy and organisational solutions were restricted by gendered understanding of the issues; society genders its population through stereotyping and maintaining myths of difference therefore restricting the valuing of the commonality of human experience and multiple subjectivities.

129 Paper: ANSA: A UNIQUE MODEL OF SUPPORTTHE Bev McDonald CRS Australia Anzac Square Specialist Unit (ASU) provides a unique continuum of vocational rehabilitation services, including pre-vocational, vocational and post placement support services for people with psychiatric disabilities. Each of these programmes

receives funding through different sources and clients move in and out of different programmes depending on their needs. The common factor across all of these programmes is the provision of support to assist clients to achieve their goals and the collaborative partnerships which exist between the programmes offered at ASU. It is well documented in the literature that clients with psychiatric disabilities have a broad range of support needs which change according to the current stage of their illness. The Anzac Square Support in Employment Service (ANSA) which is co-located with ASU has established a unique model of providing support through a bank of support workers who are trained and supported to help clients achieve their goals. The support workers may be accessed to provide support to clients across the service delivery continuum and move with the client into post placement support. The advantages of this model include: (1) the ability for the client to establish a trusting relationship with a particular support worker across the various programmes; (2) consistency of support offered across the continuum; (3) flexibility of support offered; (4) the ability to match clients with suitable support workers; (5) the ability of support workers to track the progress and adjust goals with their clients as they progress through the various programmes; (6) specialised training, monitoring and support available to the support workers. Using case study material the aim of this paper is to specifically examine the benefits to clients in providing support using this model. Particular emphasis will be placed on the nature of support provided, how it is provided, the outcomes for clients and future directions.

130 Paper: 'SENSE-MAKING IN PSYCHIATRIC DISABILITY SUPPORT' Selma Macfarlane This study began, tentatively, as an exploration of experiences and outcomes in a residential psychiatric disability support service, based on loosely structured interviews/conversations with program residents, former residents, and staff. The interviews focussed on how individuals experienced the program - what was supportive or growthful, what one's time in the program might mean in the context of wider life experience, and how (if) someone carries change or growth with them after leaving the program. As the study unfolded, I realised part of what I was doing, in looking at how the program impacted on the lives of individuals, was actually discovering how staff grapple with the evolution of an 'effective' service, and how program participants perceive and engage with the service. This process can be a way of acknowledging how the helping professions are actively involved in the creation of culture and meaning, and how this might impact on those who use services. Exploring a specific program in depth (from various perspectives) may allow us to challenge some of our assumptions and illuminate wider issues about health and illness, recovery and change, and ways of being and working. In this paper I would like to share some of the gems of wisdom, and 'truths' born of experience, reflection and struggle which have inspired my work on this project.

131 Paper: CONSENT IN CONTEXT Graham, Cheryll Graham Sonja Goldsack Wellington Mental Health Consumers Union Incorporated. Consent to treatment when a person is presenting with symptoms of a psychiatric illness is a delightful ethical issue which involves several disciplines. The position for the mental health consumer themselves is theoretically simpler, in that there is only the need to get adequate information on the proposed treatment and then make the choice as to whether to proceed or not. In practice these two steps are often not simple at all. This paper looks at informed consent from a consumer perspective, and considers both the information gathering process and the implications of consent and non consent. There will be a presentation and opportunity for discussion on: Objectives and outside issues for the mental health consumer in considering treatment options Competence to make a decision The treatment, containment and assessing competence roles of the health professional How the fear of compulsory treatment influences consent We will introduce a model which presents the objectives of the mental health consumer during the process of consent decision making. This model will demonstrate the relationship between compulsory assessment and treatment, informed consent, competence and the consumer's objectives.

133 Paper: "SURVIVING BEYOND THE BIRTH" Wendy Lauder An innovative program between the Women's Mental Health Program (Division of Psychiatry) and Maternity Services (The Bendigo Hospital). This program has a strong preventative and early intervention focus for women in the post partum period. Offered on a weekly basis as part of the educative program for new mothers this 3/4 hours session focuses on: a) The Birth Experience - recognition of the birth experience; a chance to look at expectations as opposed to outcomes and looking specifically at the feelings associated with this .b) The Emotional Changes Following Birth - from Baby Blues through to post natal distress/depression - it includes recognition of the symptoms and local options as to who to turn to if you are experiencing distress. c) The Changing role in Becoming a Parent - how to adjust to changes in the importance of taking time out for yourself and supportive networks available for new mum. Although the program is targeted specifically at new mothers, partners and significant others are encouraged to attend if available. The second part of the program is to offer training to maternity ward staff and maternal and child health nurses in rural/remote areas of the Loddon Southern Mallee Region. This training is aimed to skill up staff so that they can incorporate these elements into their own education sessions offered to new mothers. This Training package can also be used as a model within any maternity service or maternal and child health centre to compliment existing education program for new mothers.

134 Paper: PARTNERSHIPS IN PROGRESS - PRACTICAL EXAMPLES OF LINKAGES BETWEEN PSYCHIATRIC DISABILITY SUPPORT SERVICES, (PDSS) AND AN AREA MENTAL HEALTH SERVICE, (AMHS). Kim Simon , Chris Dickinson, Sue Durham Aims: Demonstrating processes for developing and strengthening partnerships between AMHS and PDSS services, through examples of existing linkages between services in the City of Boroondara, (Vic.).This presentation identifies the recent integrative changes in mental health

services and the resultant development of strong linkages and partnerships between AMHS and PDSS. Specifically we will concentrate on the development and evolution of linkage agreements, formal and informal networks and sharing of resources between Hawthorn Community Mental Health Centre, (SVMHS-Melb.), Mosaic, (a community based psychosocial rehabilitation provider - IEMHSA) and CROP (Community Recreation Outreach Program - City of Boroondara). We will discuss the move towards a cooperative approach to planning and service delivery, collaboratively identifying service gaps and maximizing service delivery resources. The presentation will include a consumer perspective of how a closely linked service system works for them. Do they view it as positive? Do they differentiate between the services? Or, Would some consumers prefer a more differentiated service system?

135 Paper: DEVELOPMENT OF A BETTER SERVICE FOR PEOPLE PRESENTING WITH EARLY PSYCHOSIS. **Bridget Organ, Kim Simon Aims:** To share practical recommendations for identifying and meeting the needs of people experiencing early psychosis, within the context of a comprehensive adult area mental health service; and To encourage a greater awareness and understanding of service provision for people with early psychosis. In recent years there has been a significant focus on the development of services for people presenting with early psychosis. St. Vincent's Mental Health Services (Melbourne), has recently taken the challenge to examine our own practice, identify gaps in service delivery and identify areas for improvement when working specifically with people in early psychosis. There has been involvement from staff across all service parts of SVMHS-M, (inpatient, community care unit and community mental health centers), in addition to external agencies, (including NGO's). This paper focuses on the ongoing processes and progress made in our commitment to providing a consistently high quality service to people presenting with early psychosis.

137 Symposium: ROADWORK'S ON JOURNEYS TOWARDS EQUALITY, RESPECT AND RIGHTS FOR PEOPLE WHO EXPERIENCE MENTAL ILLNESS Julie Leibrich, Tessa Thompson, Debbie Peterson Aim To promote discussion and action on ways to collaborate with a recovery approach to mental illness, by dealing with discrimination against people who experience mental illness. Discrimination is a barrier to recovery and contributes to illness, which is why we developed a map for eliminating discrimination. The Commission works to get agencies and individuals travelling on the many paths described in the 'map of the journeys towards equality, respect and rights for people with mental illness'. At this symposium we will describe some of the discoveries we have made on our journeys, particularly the interrelated findings from the following 3 pieces of work. Stories of Recovery We put together a book of personal stories by people who have or have had mental illness. In the stories they talk about the ways they have found to live their lives positively, despite discrimination and despite mental health problems and in many cases because of them. Scrutinising the News To find out on how to best enable people working with the media to improve the representation of people with mental illness we developed a scanning tool. We analysed ~900 newspaper clippings from 1997 and 1998 to: describe how the newsprint media presents people with mental illness to their readers identify problem areas and shining lights Preliminary findings show that media stories which feed misconceptions frequently mention violence and often use quotes from within the health sector. These stories contribute to an overall picture which depends on discriminatory stereotypes. More clarity and consistency in the way the mental health sector deals with and talks about issues of danger is crucial if we are to successfully put messages through media which address discrimination. Excavation Work Around Notions of Dangerousness: We are untangling and scoping the issues around 'danger', identified as a major problem in the media scan and in our 'stories of recovery'. We have found that false ideas that people with a mental illness are by definition dangerous and that that mental health services are primarily about providing safety for the community, are common in discourse and obstruct our journeys. We must tackle these issues within the sector, to build communities which behave fairly and inclusively towards people with mental illness. .

138 Paper: A REVIEW OF CONSUMER PARTICIPATION IN NEW ZEALAND MENTAL HEALTH SERVICES Margaret Hamilton The Mental Health Commission has a legislated responsibility to monitor and report on the implementation of the National Mental Health Strategy which was outlined in the Ministry of Health document "Moving Forward" and released in 1997.In 1999 the Mental Health Commission has undertaken a review of consumer participation to identify the extent to which the targets (which were required to be achieved by July 1998) in "Moving Forward" have been achieved in the Ministry of Health, the Health Funding Authority, and Hospital and Health Mental Health Services. Interviews were conducted with Managers, consumers involved in participation processes, and a group of consumers in each area and in the key agencies. The general findings of this project noting the diversity of processes used by these services and key agencies to obtain consumer participation (including the employment of consumers) into their policy development, planning, funding, and monitoring processes will be the focus of this presentation. Mental Health Commission, Wellington, New Zealand

of consumers in each area and in the key agencies. The general findings of this project noting the diversity of processes used by these services and key agencies to obtain consumer participation (including the employment of consumers) into their policy development, planning, funding, and monitoring processes will be the focus of this presentation. Mental Health Commission, Wellington, New Zealand

139 Symposium: OUTREACH CLINICS: SERVICE PROVISION TO THE MENTALLY ILL, HIDDEN HOMELESS AND 'AT RISK' PERSONS IN ST KILDA AND FOOTSCRAY: A COLLABORATIVE, WORKING RELATIONSHIP BETWEEN PDSS, PRIMARY HEALTH CARE, CLINICAL PSYCHIATRIC SERVICES AND COMMUNITY AGENCIES. Karen Sait, Paulo Reid, Tricia Bulic, Claire Amies In St Kilda a community response to the mentally ill, hidden homeless and 'at risk persons residing within targeted private hotels has been in place for the past 5 years. The St Kilda Project is known as 'Healthtime' and its uniqueness and strength is based upon broad intersectoral and intrasectoral collaboration. This model of service delivery has recently been adapted by the Psychiatric Disability Support Service - Western Region Outreach Service (WROS), Western Region Health Centre and other local community groups targeted to a large accommodation service in the Footscray area. In both projects several local agencies are involved in the regular outreach provision of a range of mental health, allied health and alternative health services to private hotel residents in a non-threatening and flexible way. These services are packaged and presented simultaneously and collaboratively in designated session times which is an effective and efficient use of service providers time and targets individuals who traditionally have fallen through service gaps. The key aim of both projects is to address the complex problems associated with homelessness in order to address psychiatric issues, general health, isolation, alienation and social issues. People are engaged in their own environment through the establishment of rapport and trust, with attention to physical health needs, accommodation and social supports whilst assessing psychiatric symptoms and risks associated with same. Each project is not "owned by any one agency" with all agencies prioritising resources to participate in the projects and collectively sharing responsibility for outreach sessions. Support and debriefing structures for all participating service providers are rigorously adhered to. In St Kilda 'Healthtime' is facilitated by the Mental Health Program (PDSS) of the Inner South Community Health Service with the Homeless Program of the Alfred Hospital Psychiatric Services providing additional mental health expertise. In St Kilda this innovative, multi-layered approach has positively impacted upon the private hotel environment, by addressing issues and establishing networks for residents and hotel proprietors as well as facilitating shared service provision and expertise across different service sectors. Specific strategies used, and the key achievements of 'Healthtime' will be highlighted. The presentation will include a comparison and contrasting of, the St Kilda and Footscray models and highlight the adaptability of this model of service delivery to other areas. The potential for replication of this model across several sectors is a real possibility and will be emphasised.

140 Poster: WOMEN'S HEALTH CLINIC FOR WOMEN WITH DISABILITIES Penelope Lee In late 1998, with the assistance of a grant from Vic Health and the Anti Cancer Council, the Inner South Community Health Service expanded their existing Health Clinics to address the needs of women with a physical, intellectual and/or psychiatric disability and created the Women's Health Clinic for women with disabilities. To establish and promote the Clinic a new and original poster was designed using the artistic expertise of the psychiatric nurse involved. After significant consultation with the steering committee, made up of experts in the areas of intellectual, physical, psychiatric and women's health, and coupled with feedback from consumers via a pilot project, we created the poster we are submitting to you today. The Aims of the Poster are:1) A tool to promote the clinic to a wide audience: The poster is striking - a visual feast, without being too confusing or elaborate. The language is also kept deliberately simple both in layout and text, to appeal to both consumers and workers in a broad number of venues (i.e., rooming houses, special residential services, neighbourhood houses, clinics and organisations). 2) A vehicle to reinforce worker's names and faces: Research has shown it is important for workers to reinforce and familiarise themselves with consumers to reduce anxiety and maximise the clinical experience. Therefore there is a provision to put a photo of the nurse in one of the "balloons" on the poster. 3) Demystify Pap Smears by using images of cells in an educative, creative and provocative way: Generally cervical screenings are lower amongst women with a disability. We have used cytology images depicting a range of cell morphology from healthy to infected or cancerous cells magnified between 25% to 400%. It is sinister that the more beautiful the microscopic presentation, the more serious the disease and morbid the prognosis.4) Create a 'positive' feeling The balloons have a celebratory feeling and depict the pap smears beautifully - as a 'positive' thing - rather than the uncomfortable, embarrassing, stressful or mysterious event it has been for many women with a disability in the past. By attaching beautiful images to something that is off limits to all but pathologists or histologists, the poster attempts to bridge the gap between art and science, medicine and the individual.

141 Paper: DENTAL TREATMENT SERVICES FOR PEOPLE WITH PSYCHIATRIC DISABILITIES Karen Sait, Andrew Neil, Maureen Williams, Paulo Reid, Tom Wong, John Stratford Since the Inner South Community Health Service (ISCHS) commenced providing dental services in 1994, the Service has actively targeted the most socially and economically disadvantaged groups, including people with psychiatric disabilities. People with psychiatric disabilities are in a high risk group with respect to dental pathology. The purpose of this presentation is to highlight the innovative approach that has been adopted by the ISCHS to address the oral health of people with psychiatric disabilities. In November 1998 the ISCHS commenced weekly outreach dental health sessions to people with psychiatric disabilities in community and residential venues in St Kilda, Prahran, South and Port Melbourne with a

follow-up appointment(s) as required, for clinical treatment at our Dental Clinic in Prahran. The project is a collaborative initiative of the Dental Health Program and the Mental Health Program. Its success is based upon staff from both Programs working together collaboratively within a community development framework. A Dentist, Dental Nurse and a Mental Health Worker staff each outreach session. Their respective roles will be highlighted and also the strategies used in the project. Statistical data from the project to date, indicates that the target group has serious neglect of oral hygiene and extreme problems in regard to their oral health which impact negatively on their nutrition, health, appearance, self-esteem, social interactions and opportunities. Particular dental problems include: (i) Severe gum disease(ii) High rates of tooth decay(iii) High needs for dentures(iv) Little or no knowledge among the target group about simple dental hygiene (v) Significant absence of dental health care products (toothbrush, dental floss etc.) The presentation will conclude with identified issues within the project to date and recommendations for future actions.

142 Paper: TAKING RESPONSIBILITY FOR MAINTAINING WELLNESSWHAT DOES THIS MEAN TO MENTAL HEALTH CONSUMERS ? Clare Miller   Changes within the New Zealand welfare system and in the manner in which health care services are delivered, has increased the onus on individuals to take self-responsibility for the maintenance of their wellbeing. As an occupational therapist working in a community mental health centre, it has become evident that for many mental health consumers this concept can often be frightening and uncertain and create disparities in treatment planning and service delivery. .This paper aims to explore some of the factors that may influence an individuals ability to take responsibility for themselves. These include developmental processes, cultural and societal factors and belief systems, as well as changes which have occurred within the mental health system and in particular the move to deinstitutionalisation and community based care. Taking these factors into account, this paper will explore what self-responsibility means to mental health consumers and the impact that it has on their lives and the decisions that they make in relation to their choice of therapeutic interventions .The term is frequently used within services and it is assumed that both consumers and professionals have the same understanding of its meaning and its value in maintaining wellness. However evidence from clinical practice indicates that this may not be so and as such reinforces the gap between service users and service providers in establishing appropriate treatment goals and therapeutic interventions.Such evidence highlights the need for consumers and professionals to be in dialogue with each other to increase understanding and ensure truly client centred care. Professionals and consumers must work in partnership to develop this concept of self-responsibility in a manner which enhances the personal power and choices of consumers thus aiding their personal recovery process as well as alleviating fear and uncertainty and feelings of powerlessness which may occur from lack of knowledge and understanding. Attempts to promote this way of working will be illustrated in this paper by presentation of a checklist specifically developed to enhance consumer understanding of the multi-facets of self-responsibility and to assist in developing client centred treatment goals. It will also include feedback on this tool and the concept of self-responsibility from consumer representatives and focus groups.

143 Paper: ELIZABETH'S STORY: CHANGING PERCEPTIONS Kirstin Bailey, Beverly K. Beach This paper presents the experiences of a 15 year old girl, 'Elizabeth', who is living with memories of physical and sexual abuse, her mother's suicide and with schizophrenia. The paper is divided into three sections. First, Elizabeth's own conceptualisations of her experiences are communicated via her narratives and artwork. A change in her perceptions is evident from self blame to self value, and from fear and horror at her symptoms to a growing acceptance of these as a vehicle for discovery. Secondly, the changing perceptions of Elizabeth from those that know her are reported. Narratives from her family, and inpatient and outpatient mental health workers who have worked with Elizabeth over a 2 year period. Finally, the perceptions of Elizabeth's current outpatient mental health workers are presented. These include professional reflections and an overview of her treatment package including family and cultural support, collaboration with community services and school, and individual and group therapy. In conclusion, the effective (necessary) elements of positive change for Elizabeth are discussed.

144 Paper: KIDS WITH CONFIDENCE A RURAL RESPONSE TO CHILDREN WHO HAVE A PARENT WITH A MENTAL ILLNESS Cathy Styles In 1998, the Bendigo Health Care Group Division of Psychiatry piloted a supportive education program for children aged 9 - 13 years who have a parent/s with a mental illness. Using a model of peer support, the formal aims of the program were: To create an environment in which the children felt comfortable talking about their situation. To provide age-appropriate education and information about mental illness To increase the children's ability to develop and maintain formal and informal support networks. To assist the children to identify their own strengths and resources and develop strategies for dealing with problems and conflict. To raise mental health worker's awareness of the needs of children with parental mental illness. Less formally, the main objective of the program was to assist the children to deal with the reality of living with a parent who has a mental illness in a practical sense. The program structure comprised of eight weekly after school sessions during which the group had an afternoon tea and a 'catch up', a brief education session and discussion, an activity and some free time to unwind at the end of the session. Both the formal evaluation and much positive feedback from the children, parents and case managers involved in the program has validated this model as an effective tool for assisting children and their families to cope more effectively with the demands placed on them by parental mental illness. This paper will describe the process used to plan, implement and evaluate the pilot 'Kids with Confidence' program, and outline future plans for further developing

this program to more comprehensively respond to the needs of children and parents for whom mental illness presents an ongoing challenge.

145 Paper: MOVING FROM INSTITUTION TO COMMUNITY LIVING - THE DREAMS AND THE REALITIES FOR PEOPLE WITH LONG-TERM MENTAL ILLNESS. Tom Meehan, Suzanne Drake Natasha Posner, Peter O Rourke Does the reality of community living match the dream for consumers who are currently involved in the de-institutionalisation process in Queensland? Attempts are currently underway in Queensland to return 300 people who are resident in three large institutions to the community ('Project 300'). As part of the overall evaluation of Project 300, a sub-group of 50 consumers participated in individual interviews at 6 weeks pre-discharge and again at 6 weeks and 6 months post-discharge. This component of the evaluation enabled us to explore both the expectations and realities of living in the community from the perspective of the consumers involved. While many struggled to achieve a sense of community identity, none of those interviewed wished to return to hospital. The freedom, privacy and dignity that community living has to offer appears to compensate for the isolation and responsibilities of such living. This paper will identify and discuss the issues which have emerged from the qualitative interviews. It is hoped that such findings may both enhance and direct future collaborative efforts such as Project 300, so that in future the realities can match the dreams of people with mental illness

146 Paper: INCREASING CONSUMER PARTICIPATION IN THE DELIVERY OF MENTAL HEALTH SERVICES: DEVELOPMENT AND EVALUATION OF AN EDUCATION PROGRAM. Tom Meehan, Although the involvement of former patients in the planning and delivery of mental health services is now widely promoted, little attention has been given to the training of consumers for the 'new' role they are being encouraged to undertake. During 1998, research staff at Wolston Park Hospital (Brisbane) worked with local consumers to develop an education program for consumers. The goal of the program was to provide former patients with the knowledge and skills necessary to participate in a meaningful way in the planning and delivery of services in the Hospital. Ten former patients were selected to participate in the training program which consisted of a one-month classroom component followed by three months of practical work experience in selected wards at the Hospital. The wellbeing/functioning of the former patients was monitored through the use of the (i) Perceived Stress Scale, (ii) State/Trait Anxiety Inventory, and (iii) Locus of Control Behaviour Scale. Contrary to popular belief, the wellbeing of the former patients was not adversely affected as a result of their interaction with primary consumers in the rehabilitation wards. In fact, the former patients demonstrated improvement on all measures at the end of the sixteen-week program. This presentation will be of value to consumers and service providers alike as it will provide details of the training program, the current role of program graduates (former patients) in the Hospital, and the strategies employed to overcome the obstacles to consumer involvement at the Hospital.

147 Paper: YOUNG PEOPLE'S EXPERIENCES OF SOCIAL RELATIONSHIPS IN EARLY PSYCHOSIS. Kirsten Sauer, Elspeth Macdonald, Jan Allen, Diane Albiston Young people's social relationships frequently change following an episode of psychosis. However, there is a lack of understanding of the impact and implications of these changes for adolescents and young adults. This paper aims to explore young people's experience of social relationships in recovery from first-episode psychosis. Six young people from the Early Psychosis Prevention and Intervention Centre (EPPIC) Recovery Group Program in Melbourne, Australia, participated in the study as co-researchers. A phenomenological approach focusing on the experience of social relationships was used to guide collection of data through indepth interviews. The data were analysed using an adapted phenomenological method to construct a description of participants' collective experience. Seven themes and a final composite description suggested that experience of social relationships can be understood in two ways. First, the experience of social relationships relates to "normal" life demands and challenges that are typical of the transition period of late adolescence to early adulthood. Personal narratives by the first author of this paper highlight the universality of these age-related demands. Secondly, the experience of social relationships involves young people coming to terms with the major impact and implications to their lifestyles arising from their experiences of psychoses. However, the main essence is young people's struggles to integrate two separate experiences at this current stage of their treatment. The findings highlight the importance of client-centred approaches in helping professionals acknowledge the "normal" human demands on clients, as well as remaining aware of the illness experiences and the meanings of these for clients.

148 Paper: YOUNG PERSONS GROUP ESTABLISHING A SOCIAL GROUP SPECIFICALLY FOR UNDER 25S IN AN ADULT MENTAL HEALTH SERVICE. Sara Simpson, Tara Greenwood This paper will discuss the setting up of a young persons group by an occupational therapy student on placement at a community mental health service. The group commenced in October 1998 and continues on a weekly basis. Members are referred or seek attendance. Activities are of a social recreational or cultural nature chosen each week by the consumers themselves. An occupational therapy student and occupational therapist attend to support and facilitate group processes. Recently diagnosed young persons entering the service were seen to have special needs. Early intervention and prevention of disability has been well documented in the literature and will be addressed in this paper with particular reference to the social recreational educational and vocational needs of young clients. Young people are frequently disconnected from their peers following an illness and often need to seek new friends because of past behaviours requiring change. Main achievements have been: operating a sustainable group programme in an environment of economic rationalisation demonstrating a level of satisfaction by evaluation increases in self esteem and self confidence facilitating networking

and peer support within and outside the group social skills have improved knowledge of facilities has improved evaluation formed the basis of a funding submission to State Government to enable more expensive activities to be available eg. abseiling

149 Paper: WHAT IS IT ? WHAT CAUSES IT ? - FREQUENTLY ASKED QUESTIONS. HOW THE ANSWERS WERE MADE AVAILABLE TO CONSUMERS BY AN EDUCATIONAL PROGRAMME INTRODUCED INTO A MENTAL HEALTH SERVICE. Sara.Simpson,Marion Wilde, Lenore.Meldrum, Peter.Yellowlees. A psychoeducation programme was developed and introduced into the Mental Health Service of the Royal Brisbane Hospital District Health Service in January of this year. Information packages containing frequently asked questions and their answers were developed and circulated via group and individual sessions. These packages also contained current brochures and fact sheets, and informed consumers of resources available - internet sites, books and videos. This paper discusses the development and the implementation of this ongoing programme. The results of a questionnaire circulated to consumers and staff to assess interest and topics for inclusion will also be tabled. The different responses obtained from the inpatient and the community staff led to a different approach and presentation of the material. GPs and private psychiatrists were also surveyed. The similarities and the differences between professions, inpatients and community staff, and consumers and staff will be presented. Two staff positions spend half time on the programme. They are responsible for creating the packages, coordinating the programme, initially running the group sessions for consumers and introducing the material to staff. A reference group with consumer representation was established to monitor the content and to offer suggestions. The material is for consumers. The packages are available on the internet on the mental health service homepage, consumers and staff can access this from computers located within the service .Preliminary evaluation has shown a good response and the packages are available in most areas of the service. Copies will be available at the presentation.

150 Paper: INDIVIDUAL ADVOCACY : CHALLENGING THE REALITY & THE DREAM. Jen Cousins : Individual Advocate for mental Health Consumers, Disability Action Inc. Individuals with mental illness are often alone with their struggles to exercise rights and express wishes. They find themselves continually challenging the boundaries, labels and involuntary treatments which have been imposed upon them on the basis of best interests. These decisions are regularly in direct opposition to the individual's express wishes. In fact it is frequently assumed that the individual is unable to have dreams and realities different to those which are imposed upon them or socially constructed around them. The best interests regime may even find it difficult to understand that the individual's dreams are not solely about being well. Advocacy for individuals with mental illness often questions this indifference to the individual's wishes by providing moral support and practical assistance to help the individual to validate their rights and express their wishes. In this sense advocacy is a critical response to the tendency for other people to assume that they know what is best for an individual. It is underpinned by an honest belief that the individual is entitled to express their wishes and to expect that their wishes will be attributed the same value as those of the best interests regime. This paper will attempt to outline the concepts of expressed wishes and best interests, highlighting how the two concepts differ and to what extent they maybe compatible. I will then discuss the value of individual advocacy for mental health consumers which is based on the principles of expressed wishes and provide some examples of the valuable role advocacy can plays in respect of an individual's well being and quality of life. To conclude I shall propose several strategies for working together to validate individual self worth and the delivery of quality services by acknowledging and incorporating expressed wishes into the best interests equation.

151 Symposium: STRATEGIC PROGRAMMING IN MENTAL HEALTH SERVICE   PLANNING AND POLICY: EXAMPLES OF GOOD PRACTICES Duane Pennebaker, Geroge Lyston, Maryann Howley, Helen McMahon, David Saunders, Karen Milligan, Janet Peacock The aim of this symposium is to present examples of recently completed work in strategic programming in mental health services planning and policy. Each paper represents aspects of a strategic program framework focused on codifying and elaborating policy directions. Policy formation is seen as a dynamic process that is shaped by many sources of influences including government, service providers, consumers and carers and health department officials. The main goal of the strategic program framework is to translate intended strategies into realised ones. Paramount elements within the strategic program framework are the key roles of analyst, catalyst and strategist. In addition, learning is seen as a required outcome of strategic programming. Each of the papers represents the various use of the strategic program framework as well as reflecting the key components for good practice that is analyst, catalyst and strategist. By the end of the symposium participants will be able to :Identify common themes inherent in good practices in the strategic program framework for mental health service planning and policy as represented in the symposium papers Describe principles and good practices that provide the basis for effective strategic program development. Appreciate the importance of having clear processes and goals as fundamental to good practices in strategic program service planning and policy development in mental health. Appreciate the importance of learning as a critical good practice element in strategic program development.

152 Paper: AN EXAMINATION OF DATA INTEGRITY ACROSS TWO TASMANIAN MENTAL HEALTH CLIENT DATABASES. Andre Jenkins, Ken Kirkby, Maxine Croft, Brett Daniels 1Background: Two versions of the same mental health client database have been independently prepared for use in academic research and client service delivery. The former used clerical reviews to uniquely identify individuals, while the latter used probabilistic record linkage. Client data for the period 1984 to 1989 was held in both systems. Aims: To examine discrepancies

between the probabilistically linked and the clerically reviewed versions of the client databases. Methods: Descriptions of the number of client contacts by diagnosis type and demographic category in this period, for the two databases are compared. Comparison of the longitudinal records for a subset of clients in common, is used to ascertain the effects of method of matching on the creation of patient. A sample of mismatched records from each system is further analysed to ascertain how the logic of probabilistic record linkage has been applied and to assess the resulting inaccuracies. Results: De-identified examples are presented of discrepancies detected in records compiled using the two methods. The results of research in progress on quantitative comparisons of overall frequency and types of discrepancies will be presented Conclusions: Comparison of two mental health client databases prepared independently from the same service data source provides an opportunity to quantify and trace sources of inaccuracy in data matching and processing.

153 Paper: DREAMING REALISTICALLY: SELECTING AND IMPLEMENTING A NEW MENTAL HEALTH INFORMATION SYSTEM IN TASMANIA. Andre Jenkins, Adam Clarke, Maxine Croft, Meredith Harris, Allen Morris Mental Health Services (MHSs) have an obligation to deliver effective services to their patients and clients in an efficient and equitable manner. MHSs are increasingly required by funders and administrators at Agency, State and Commonwealth levels to provide information regarding client profiles and clinical activity, to conduct benchmarking activities, to promote continuity of care, and to routinely monitor and evaluate the outcomes of the services they provide. Information systems that enable the collection of data describing the socio-demographic, clinical and service utilisation of MHS clients, and the collection, processing and reporting of detailed information regarding service outcomes, are now recognised as critical tools for meeting the many obligations of MHSs .In 1998, Tasmania undertook a consultancy project to identify an information system for use in its MHS and has begun implementing that system in a difficult fiscal environment. Tasmania had many dreams about what such a system might 'look like,' however the experience of earlier stalled projects and current fiscal constraints meant that these dreams had to be tempered by realistic estimates of what could be achieved. Our paper outlines those dreams and the realities of delivering them. These include: meeting current clinical and management information needs; accommodating future NMDS and information-related developments; enhancing service delivery through routine outcome measurement; identifying an affordable, available, information system able to be implemented in a short timeframe (under 6 months); developing a comprehensive and affordable training package; easy integration with existing inpatient systems (promoting continuity of care); and, negotiating dependable and continuing system support We demonstrate that while compromises have to be made, a system which is both clinically and administratively useful can be implemented. A detailed example of this approach - the construction of the patient master index - will be discussed.

154 Paper: TE KOROWAI AROHA(The cloak of grace)A kaupapa Maori service Laurie Popata, Audrey Wilkinson, whanauIn Maori culture, the importance of whanau (family) and kin relationships are deeply significant. Maoritangi actively encourages individuals to recite (without paper reference) their many-generational whakapapa (genealogy) and within that context to acknowledge the place where their tribal canoe first landed on the shores of Aotearoa (New Zealand). Skill in te reo (the language) is also highly esteemed. Immersion in the culture enhances a strong sense of pride, identity and place in society. Not all Maori have had the opportunity to experience such positive influences and very few Maori clients of BMH have this background..Recognising the significance of culture in an individual's journey towards recovery, Maori staff in 1994 introduced an affirmative action policy which deliberately strengthened Maori cultural input to the daily life of a 24 hour residential rehabilitation home in South Auckland . Of 8 residents - 4 were Maori and 4 tauiwi (non-Maori). Maori clients had long standing histories of mental ill health with multiple past and recent admissions to hospital. Mental illness had caused most to lose close contact with whanau and/or friends, and attempts to build bridges back to happier family relationships had met with little success. The programme encouraged the use of te reo,. participation in rituals and ceremonies including karakia (welcoming) and waiata(singing). Several evenings a week meals would reflect Maori dietary preferences and all clients would share in the preparation and cooking. This communal approach had positive effect on social relationships and the level of cooperation between staff and residents. By 1995 two kaupapa homes had been established and positive results were obvious. Formerly almost inarticulate clients were using the language and confidently engaging in ceremonies. Mental wellness improved with rare readmissions to hospital and greatly enhanced prospects of recovery. Some family relationships began to be healed and whanau would be present at house meetings, social events and sleepovers.. The kaupapa continues to strengthen and widen its influence throughout the community. It now also influences the content of our prevocational training programme where te reo, wood and bone carving, music, drama and dance are key modules.

155 Paper: CARING FOR SUICIDAL YOUNG PEOPLE IN THE EMERGENCY DEPARTMENT AND THE COMMUNITY: THE BLACKTOWN YOUTH SUICIDE PREVENTION PROJECT Ann Fry, Maree Teesson, Bill Moloney, Declan O'Riordan, Sue Roseby, Yvonne Zurynski. A multifaceted study on youth suicide prevention was conducted in Western Sydney. Two aims were to improve health care to young people at risk of suicide when they present to the emergency department and to implement a coordinated care plan of active follow-up for each young client. The number of young people presenting to ED for intentional self-harm is alarmingly high with eighty young people presented to the EDs with intentional self harm over a nine month period. Fifty per cent had a mental illness or

disorder. They had high levels of depression and suicidality and moderate disability. A high proportion were using drugs and alcohol. Young migrant women were overrepresened. Previous attempters had significantly more depression and disability. Males were significantly more suicidal and disabled. Interpersonal conflict was the most common precipitant. Thirty-five of the 71 clients underwent a follow-up assessment six months after initial contact which was a high follow up rate. There were significant decreases in anhedonia, feelings of worthlessness or guilt and for lack of concentration, depression, disability and suicidality. The number of clients using drugs increased. Previous attempt was the only variable which was independently and significantly associated with depression as measured by CES-D, was previous attempt. The six-month CES-D score was significantly higher for those patients who had previously attempted suicide. The Project demonstrated effective intervention at the individual and systemic level. This paper will present the evidence and discuss the implications for caring for this vulnerable group of clients in the emergency department and the community by mental health services.

158 Paper: THE REALITIES OF SUICIDE IN MIGRANT COMMUNITIES: FULFILLING THE DREAM OF PREVENTION FOR ALL Pierre Baune, Abd Malak, Neda Dusevic, Maria Cassaniti There is a substantial body of evidence that children of parents with mental health problems are at increased risk of also developing mental health problems. To date a number of programs have been developed to address the needs of young people living with parents with mental health problems. However, there is little information on the extent to which these programs have targeted, or are appropriate to the needs of young people from culturally and linguistically diverse backgrounds. The research project was undertaken to investigate, develop and promote the mental health of young people from culturally diverse backgrounds who have a parent with mental health problems This paper will report on the first stage of the project which involved consultations with*: (1)* Young people between the ages of 12 - 24 from Vietnamese-, Khmer-, and Spanish- Speaking backgrounds, who have a parent with a mental health problem; *(2)* Parents from Vietnamese-, Khmer- and Spanish-speaking backgrounds, who have experienced a mental health problem; *(3)* Sixty five mental health/ general health workers, youth workers, bilingual counsellors and stakeholders in the community. The presentation will discuss findings from the consultations relating to: (i) the key issues facing young people from Vietnamese-, Khmer- and Spanish- speaking backgrounds living with a parent with a mental health problem; and (ii) the key issues/problems facing parents with a mental health problem. The presentation will outline the future stages of the project as well as strategies that youth health services and mental health services can take to improve the delivery of services to young people living with a parent experiencing a mental health problem.

160 Paper: THE DEVELOPMENT AND INITIAL EVALUATION OF AN ADOLESCENT CONSULTATION LIAISON SERVICE MARINOTO Robyn Johnstone, Nikki Coleman Waitemata Health operates two Child, Adolescent and Family Services, one on Auckland's North Shore and one in West Auckland serving the Waitakere area. In 1997, $400,000 enhancement money was allocated from the Mason Fund to be divided between the North and West Districts. Initially, it was decided to utilise $200,000 to provide an adolescent service to the North District of Waitemata with the expectation that it would be extended to cover the West District the following year. The existing service catered for children/young people up to the age of 18, and their families. The geography of the area dictated that the mental health service for this client group is split into teams on separate sites, but both teams fell short of critical mass. In addition, the areas served by each team varied demographically with particular differences in cultural mix. Effective operation was impeded by a two-year waiting list, which, in turn portrayed the service as inaccessible and not useful to outside agencies. This was particularly relevant to those service providers catering to the adolescent age group where response times are significant. The task was to set up an effective service designed specifically to meet the mental health needs of adolescents but within the wider health, education and social service infrastructure. The challenge was to do so within the significant budget constraints. The presentation paper describes community consultation, needs analysis, service model conceptualisation, project development and subsequent evaluation at one year. The focus is on the experience of initiating the service and aims to provide information that will be of use to those considering a similar exercise, although relevant clinical data is included.

161 Paper: WHAT'S A GOOD OUTCOME? DIFFERENCES IN THE REALITIES OF CONSUMERS, FAMILIES, STAFF, AND COMMUNITIES IN MÄORI AND MAINSTREAM SERVICES Geoff Bridgman, Lorna Dyall This paper looks at the responses of Maori and non-Mäori consumers, families, staff, and community elders to a number of issues presented over a series of 24 focus groups. Issues examined included the meaning of "wellness" and "unwellness"; the meaning of "recovery"; the meaning of "outcome"; the meaning of "culture" and its importance in service delivery, the role and contribution of whänau, family or friends; and the role of the community. In addition consumers, family and staff trialed the following measures and commented on them. Consumers: BASIS-32: The Mental Health Consumer Survey; and a satisfaction/needs survey based on the Community Support Options and Tangata Whenua standards from the National Mental Health Standards. Staff: BASIS-32 (adapted for staff); the HoNOS; and the Mental Health Case Manager Survey. Families: the Perceived Family Burden Scale; and a caregiver version of the consumer satisfaction/needs survey above. People were also asked to comment on process issues around outcome measurement. The results show that stakeholders have distinct realities which influence their perceptions of the outcomes they want from mental health services and how these should be measured. The paper involves two separate presentations from the research coordinators, one focussing on the mainstream services, and one on Mäori services.

162 Paper: FROM DREAM TO REALITY: EXPECTATIONS VERSUS ACTUAL EXPERIENCE OF NEW GRADUATE NURSES IN THE MENTAL HEALTH SETTING Stephen Van Vorst What do nursing students think about their experience in the mental health setting? Do these experiences develop positive and appropriate beliefs and attitudes towards the care of people with mental health problems? What do new graduate nurses think about their experience in the mental health setting? Does the reality of the postgraduate experience meet the dream of the undergraduate experience? Over the past 15 - 20 years, Australia has seen many changes which have influenced the care of people with mental health problems. One of the most significant changes has been the transfer of nurse education from hospitals to the tertiary education sector. To date, little evaluation of this change has been conducted. This paper reports the findings from a 2 1/2 year longitudinal study which explored new graduate nurses' perceptions of their experience in a variety of mental health settings. One of the findings of this study was that most of the participants were generally quite content after 2 1/2 years of practice in the mental health setting. However, the participants also expressed a sense of powerlessness and frustration over the severity and long-term nature of illness in the hospital setting and concerns about their need for varied levels of continuing support. This paper discusses the implications of this research for educational and clinical services.

163 Paper: CARTOON BEST PRACTICE Janet Peters This presentation will be undertaken solely using cartoons to humorously illustrate some key themes around both clinical and managerial practices in mental health services. It is based on the premise that we all over time take on certain roles that may not be helpful for what we are all striving for, that is, to effectively serve the interests of consumers and families. The aim is to strongly (but humorously) challenge and provoke the audience by presenting some common

"stereotypes" or roles in terms of personal and professional styles of working in mental health. These apply to clinical and community staff as well as managers. The outcome will be that people will have the opportunity to think about where they personally fit in terms of these roles and to raise options in terms of possible ways of doing things better. It is always a challenge to practice what one preaches!

164 Paper: THE COMPLETE CONSUMER SATISFACTION SURVEY Sarah Gordon The New Zealand National Mental Health Standards apply to all mental health service providers across New Zealand. For the purposes of this paper the relevant standard is number nine, entitled "Consumer Participation". Specifically, consumers must be involved in the planning, implementation and evaluation of mental health services. Examples of how this is to be achieved include the establishment of consumer evaluations. Consequently, at the beginning of this year I began a project to facilitate the development and implementation of a "consumer developed" consumer satisfaction survey for evaluation of the community mental health services provided by Healthlink South. A community services team, comprised of approximately 12 Healthlink South mental health consumers, was established to develop the survey - delineating the outcomes to be assessed and the way the outcomes are measured. The aim of this paper is to present an overview of the process involved in developing and implementing the consumer satisfaction survey. The following topics and issues will be addressed: How did consumers respond to the request to write a satisfaction survey? How was the membership of the consumer group (to develop the survey) established? Did group members need and/or want research training? What process was used to actually write the survey? What difficulties were encountered in the development of the survey? How were they overcome? hat does the group think of the survey tool they developed? How does the group feel about the process involved in developing the survey tool? What does the survey tool include? How does it present? (quantitative versus qualitative).What are the differences between this survey tool and those commonly used in the past? How did other consumers respond to being asked to participate in a "consumer developed" consumer satisfaction survey? Did it appear to alter the response rate? What do the preliminary results show? Do we gather better and/or more information using a consumer developed survey tool? Where to from here? The objective of this paper is to provide sufficient information for other healthcare providers to establish processes for the development of consumer satisfaction surveys

165 Paper: FROM ARRANGED MARRIAGE TO A LOVE MATCH? 'INTERESTING TIMES' AND THE GROWTH OF A CONSUMER- DRIVEN PARTNERSHIP. Robert Graham, Michael Appleton The Rehabilitation program of the Ryde Community Mental Health service has undergone several changes and developments in recent years. These accord with current National, State & Area Policy, and consumer partnerships. Redirection of scarce service resources may meet newly identified needs, yet unintentionally abandon others. When this happened, how to meet both? Is Necessity the only mother of invention? A service initiated response to resulting consumer unrest saw concurrent joint reviews of the strand of the Rehabilitation program known as ' Wicks Cottage - Living Skills / Rehabilitation Centre'. Simultaneously, The local Consumer Network proceeded independently and set up their own social committee. Both groups clearly identified consumers' primary concern as: Access to a 'safe place' which provides social & leisure opportunities for consumers of a mental health service, who find the only alternative prospect ie that of wholesale 'integration' into general community activities, either too uncomfortable, or unattainable. The subsequent evolution and transformation of this centre has witnessed the convergence of both groups, and demonstrated some dynamic virtues (and challenges) in a consumer-driven partnership. The 'place' is now established as "The Hut". To meet consumers' needs, the experts and dynamos are proving to be consumers themselves. Emerging outcomes suggest this initiative may be viewed as a viable model for realising key Health Promotion aims. It has clearly demonstrated the value of providing a supportive, accepting and "user-friendly" environment for predominantly social & leisure activities. Ongoing challenges for the partnership lie in nurturing a shared vision, so that the representative processes and structures developed to date continue to create programs offering wide opportunities for consumer participation.

166 Paper: OVERCOMING HETEROSEXISM IN THE CLINICAL SETTING Jae Condon In recent decades Gay and Lesbian rights movements have done much to address inequality on the basis of sexuality. However, no matter how far we may have come, many barriers remain for gays and lesbians. Heterosexism and homophobia are everpresent, and are often endorsed by the state, the church and other bodies of authority. These issues of heterosexism and homophobia are evident within the medical model, and are adopted in mental health and psychiatry .These barriers prevent gays and lesbians from engaging with mental health services. Depression and suicide are pronounced issues for the gay and lesbian

population. The need for therapeutic intervention in these cases is paramount. This paper aims to describe homophobic barriers preventing access to mental health services. Explanation as to the origin of these barriers will be offered. Practical strategies for overcoming such barriers will be outlined. These strategies are able to be implemented by clinicians in their day to day interactions with consumers. Case studies will be offered to illustrate the difficulties experienced by gays and lesbians in engaging with mental health and related community services. Evidence of the effectiveness of the suggested strategies will also be discussed in case studies.

167 Paper: HOUSING AND AUTONOMY Annette Sutherland Ruth Teasdale Comcare Supported Rental Service commenced a pilot project and is now in its fourth year of operation, providing or supporting housing for up to 90 people. This paper will initially present the Service in its present form: The flat hunting service – supporting people to find their own private rental Voucher system for free property services – the development of client choice in the selection of budgeted services (e.g. lawn mowing, laundry services, spring cleaning) Owning and leasing property – the specialist role of the not-for-profit benevolent landlord role Landlord liaison – dealing with private and public landlords, particularly around issues of discrimination. Supported Rental does not provide housing for a fixed term which is dependent on goals reached, but helps people find and maintain a home which is their own for as long as they wish, or external circumstances will allow. Many of the people the Service has assisted have seldom or never had the opportunity to call a place home, or be in control of their housing environment and this paper will examine the impact of this "home deprivation" on clients and services. This paper will also discuss the issue of the separation of housing and other support services (particularly in reference to the potential conflict of interest between the landlord and support roles) and the ramifications of the move towards flexible levels of home based care.

168 Paper: UNIVERSITY & INDUSTRY WORKING TOGETHERI'D LIKE TO SEE THAT!! Michael; Struth Modern community based treatment for people who experience mental disorder presents many challenges for health care services, but none so great as the shift from a medical model of symptom reduction to a model of integrated mental health care with a focus on recovery. Continued improvements in biological treatments have emphasised the requirement for evidence based psychological and social treatments that value add to optimal drug strategies and enhance comprehensive treatment efficacy. Such advancements create enormous challenges for the future role of nurses; a role demanding that the nursing profession confront the issue of accountability for health, an attempt to redefine mental healthcare so that it moves beyond the mere absence of psychopathology. This enormous task attacks the core of mental health nurse training and practice and requires collaborative relationships between tertiary facilities and industry. A mutual recognition between the Warrnambool and District Base Hospital and Deakin University that the credible future of nursing in the field of mental health requires tertiary and industry collaboration sparked an alliance. The alliance was formalised with a memorandum of understanding. The understanding is based on a commitment to the relentless pursuit of excellence in mental health nursing. The content and processes of mental health nurse training must equip nurses with the knowledge, skill, and political prowess, not only to survive, but to essentially effect empirical treatments for consumers (clients and carers) across a diverse range of settings. A reference group comprised of subject matter experts, selected from a range of public and private health care facilities and academic institutions, have facilitated the project. It is anticipated that this project may, in some small way, contribute towards" nswering important questions about the roles between healthcare and health" (Ross et. al., 1998, pg. 49)Influence health status outcomes deserved and expected by consumers Focussing nursing practice in the mental health field on evidenced based practice Propel the sustainable future of mental health nursing into the new millennium.

169 Paper: LEAST RESTRICTIVE ALTERNATIVES :MANAGING CLIENTS WITH SUICIDAL IDEATION IN THE COMMUNITY. Zoey Doueal, Tracey Pearce It has been estimated that almost 95% of individuals who commit or attempt suicide have a diagnosed mental illness or mental disorder. Notwithstanding, the current principles of mental health care are to treat clients in the least restrictive environment. Mental health clinicians involved in crisis assessment are frequently required to determine which setting is the least restrictive, whilst ensuring the provision of a safe environment. In ideal circumstances, the safe environment would be within the community. In extreme cases, an inpatient psychiatric unit is often identified as a necessary intervention for clients with suicidal ideation. However, clients at risk of self harm continue to be successfully managed within the community. This has positive implications for client's prognosis. However, the decision to manage at risk clients in the community is not simple and requires careful consideration by the clinical treating team before being utilised. Factors that

preclude the use of home-based management are the presenting risk level of the client and the ability of carers to provide a safe, supportive environment in high risk situations. The aim of this paper is firstly, to discuss the difficulties in the identification of at risk clients and to provide a rationale for the benefits of community based risk management. Secondly, the paper identifies what is required to manage at risk clients in the community and assists with determining when community based management may place the client at greater risk and thus necessitate in-patient care

171 Paper: MALE GENDER IN FOCUS:SOCIOLOGICAL AND PSYCHOLOGICAL IMPLICATIONS OF MENTAL ILLNESS FOR MEN. Zoey Doueal Men's experience of mental illness has been foreshadowed by the dominant focus in recent years on women's experiences of mental illness. This persists despite information that suggests a diagnosis of a major mental illness such as Schizophrenia is frequently made at an earlier age for males, with this diagnosis often leading to poorer course and outcome of the illness. Whilst biological factors may contribute to the earlier onset of illness, sociological factors and psychological responses can be viewed to play a significant role in determining the course and outcome of an illness episode. Therefore, it is important for these factors to be carefully considered and targeted within treatment and management of the individual's illness. When a diagnosis of major mental illness is given to men, the associated changes in functioning and perceived stigma of having a mental illness can serve to compromise the individuals sense of self worth which also carries implications in terms of their social functioning. Thus, areas such as education, career, economic status and interpersonal relationships may be affected and traditional role expectations for males may not be fully realised. Sociological factors of Australian society that serve to disadvantage women, can also be viewed to impact negatively on men. Negative responses to perceived lack of role fulfillment include alcohol and illicit substance abuse and increased propensity for harm to self and others. This paper aims to promote awareness of these issues, their dynamics and implications for the individual. Further, this paper aims to address how acknowledgement and timely intervention in addressing these issues in the treatment of mental illness may promote better sense of self worth and may improve the outcome of illness

172 Paper: D.I.D. WHAT, HOW & WHEN Beverley Searle Dissassociative Identity Disorder is misdiagnosed and mistreated. Mental Health Nurses, social workers and counselors say they know very little of the disorder. This talk is to explain how the disorder originated, the difference from D.I.D. and Schizophrenia and basic help which is needed when you are confronted with a person suffering with this disorder. The presenter Beverely Searle had the disorder, publicly talks to universities, conferences and is the Chairperson of DISSSA Inc the organisation for D.I.D. in SA. The presentation is suitable for consumers, para-professionals and professionals.

173 Poster: OUR LIVES OUR CHOICES III Beverley Searle This poster will be on Our Lives Our Choices III conference to be held in July 1000 in Adelaide. There was a logo competition for consumers and now that logo is being designed by another consumer into the poster.

174 Paper: THE MID WEST NON-ENGLISH SPEAKING BACKGROUND CARER'S PROJECT: A QUALITATIVE STUDY ON THE NEEDS OF FAMILIES CARING FOR A PERSON WITH A MENTAL ILLNESS. Trish Saunders, Jill Collins Background. The Mid West Area Mental Health Service in Victoria has a history of ongoing improvement of service provision to the local multicultural community which has 41% of it's population born overseas, and more than 70 languages are spoken. Aims of the Project. The project aims were to identify the needs and to develop appropriate service responses to the target group of linguistically and culturally diverse carers in the Mid-West area. Methodology. The target group were Mid-West NESB carers. Using qualitative methods, a needs study was planned. The study focused on Vietnamese, Croatian, Macedonian, Serbian, Maltese, Greek, Italian and Turkish communities. Consumer and carer written consent to participate was a prerequisite. The interviews, using interpreters when required, were conducted with 42 NESB carers. Questions were asked about NESB carer's experience of the mental health system, the emotional, physical and financial burden of care, how they coped, their knowledge about treatment and their experience of mental health staff's attitudes towards them. Findings. he findings provide qualitative and phenomenological evidence of the experience and understanding of the NESB carers in their own words on issues for them in caring for a mentally ill family member. The response from the NESB carers to the needs study carried emotional depth and information about their understanding that has broad ramifications for the Mid West in it's service delivery to NESB carers. Two main themes that came through were the enormous isolation the carers lived with and terrible financial burden. The results have provided evidence of service gaps for carers of ethnic and linguistically different backgrounds. The recommendations focus on the need for carer emotional support, a multi-dimensional approach to meeting staff's needs for further knowledge and understanding about issues for

families of non-English speaking background and the need for supported accommodation options in the Mid-West.

176 Paper: CANNABIS USE AND THE EMERGENCE OF FIRST-EPISODE PSYCHOSIS
Samantha Loi Timothy Rolfe, Jayashri Kulkarni Background Since the 19th century, there has been great interest in the aetiological role of cannabis in the development of psychosis and schizophrenia. Studies have shown that cannabis may cause an earlier onset of schizophrenia (Andreasson et al. 1987); an exacerbation of symptoms (Treffert 1978); and a decrease in negative symptoms (Rottanburg et al. 1982); with perhaps a concurrent increase in positive symptoms (Linszen et al. 1994). There are studies that demonstrate that drug-abusing patients with schizophrenia have a shorter course of psychosis, and recover earlier than non-drug abusing patients (Rottanburg et al. 1982). However, only recently have people been interested in the reasons why individuals use cannabis (Dixon et al. 1991, Warner 1994), and there is even less investigation into the reasons why they continue to use cannabis (Baigent et al. 1995). Some studies have investigated general substance abuse, but none have specifically studied cannabis. Study aims This project is designed to investigate the motivations for initial use and continuation of use of cannabis, as well as reporting on the changing amounts of cannabis used during the prodrome of first-episode psychosis. The potential significance of this project would include:- being able to develop a management plan that would assist in intervening early in the process of cannabis abuse, and- the use of a semistructured interview that would be able to assess a person's experiences with cannabis and how it affected the emergence of their psychotic symptoms. Conclusions Data concerning the above will be obtained from 10-30 participants and their carers. These will be analysed qualitatively for similarities and commonalities. The study is exploratory in nature and is expected to generate more questions than it answers, yet it is an important first step in attempting to conduct studies of the relationship between cannabis use and the onset of psychosis.

177 Paper: WHAT IT MEANS TO BE A BILINGUAL CASE MANAGER Vesna Ilijevski:, Diana Jurcic, Giovanna Pennella Stephen Ziguras This paper will describe an innovative bilingual case management program in the North Western Health Care Network Mental Health Program and some of the cultural issues emerging from their work. Eleven bilingual staff are employed in case management positions in four Area Mental Health Services. The languages spoken by staff include Croatian, Greek, Italian, Macedonian, Turkish and Vietnamese. The roles of staff include case management with a focus on clients from their language group but also including clients from other backgrounds, joint case management and secondary consultation to other staff, family and consumer education and support and community education. This paper will address both the positive and negative aspects of being a bilingual case manager from the perspective of bilingual case managers themselves. The interaction between ethnicity, culture and mental illness is a central component of the bilingual case manager's work. In view of this bilingual case managers can often confront cultural barriers themselves, such as in situations where a client's cultural issues may conflict with accepted medical explanations about illness, causation and treatment. Despite some of the challenges and complexities most bilingual staff have agreed that a shared language and ethnic background has led to quicker engagement and establishment of trust. Networking with other ethnic specific community services has also proved useful for the bilingual worker, the client and the client's family. Working with families has also been a key feature of bilingual case managers' work. This paper will highlight the issues faced by Macedonian families/caregivers when dealing with an ill family member and a mental health system of which they have little or no understanding. Through the assistance of bilingual case managers, both clients and their families have been able to access information and gain education in their own language. The development of support groups for families/carers is a desired outcome.

178 Paper: EVALUATION OF A PRIVATE PSYCHIATRY SHARED CARE SERVICE USING VIDEOCONFERENCING IN A RURAL COMMUNITY Craig Kennedy Many psychiatry services across Australia utilise videoconferencing technology to enhance existing service provision to people with mental health problems and mental disorders. In Queensland over 300 hours of videoconferencing per month is utilised across 50 sites to support clinical and educational activity in psychiatry. General practitioners are now being involved with private and public psychiatry services through using videoconferencing and visiting services. An economic evaluation is currently being finalised to examine the health outcomes, costs, utilisation, accessibility, quality, and needs of such services in a rural community in Queensland. These outcomes are being compared to two other similar communities. The paper will present the service model used and the methodology used in the economic evaluation. Preliminary findings over two years suggest that: (30 percent of people referred for psychiatry services used videoconferencing; (60 percent of people referred for psychiatry services were not offered

videoconferencing and treatment was delayed; (90 percent of people referred for psychiatry services indicated they would use videoconferencing if offered; number of referrals to private psychiatrists has slightly increased; service costs are less than a visiting consultant; costs to consumer and community are less than alternatives; referral is mainly for management of consumers with a previously established diagnosis; and, consumers and service providers have a strong acceptance of the technology and timeliness of the service. The methodology used provides a model for examining cost effectiveness of videoconferencing in rural communities, along with key performance indicators needs to ensure service outcomes are achieved. The service model is currently being expanded into two other rural communities geographically adjacent to the existing study area

179:Paper: UTILISATION OF VIDEOCONFERENCING TECHNOLOGY IN QUEENSLAND MENTAL HEALTH SERVICES Craig Kennedy, Peter Yellowlees Videoconferencing technology was first introduced into Queensland Mental Health Services in 1995, and today there are over 130 videoconferencing units across health facilities in Queensland Health, of which approximately 50 are accessed by mental health services. Mental health services utilise videoconferencing to improve access of existing clinical services to health consumers, to improve the quality of peer supervision and support, to increase the range and interactivity of educational sessions, and to expedite administration processes. The paper aims to present an effective method for auditing the use of videoconferencing technology, in addition to examining the differences in utilisation across various integrated mental health services in rural, regional, and urban areas. Utilisation of services is described in terms of: referral patterns; service models; types of health professionals involved; number of consumers; and, associated costs from health service perspective. The information presented will represent data collected at six monthly intervals over a two year period. Videoconferencing technology has certainly made a significant impact in health services in Queensland, both in terms of mental health and other specialties. Videoconferencing cannot solve the problems or complexities of providing services to rural areas, utilisation of such technology is about making an appropriate use of it within the existing health care services

180: Paper: CONFIDENTIALITY AND EFFICACY IN USING VIDEOCONFERENCING TECHNOLOGY Deborah Oong, Mr Craig Kennedy Videoconferencing technology is widely available for use within mental health services in the public health system. The introduction of any technology in health care raises the issues of confidentiality and efficacy of its use in clinical practice by health professionals. Videoconference technology is generally seen as the 'talking head style consultation', however, it can include image transfers and direct transmission of consumer records. If health services provided require assessment, evaluation, or decision, then those services constitute practice of health care irrespective of whether they are provided in person, over the phone or by videoconferencing. Issues raised include . Who should receive care via videoconferencing? What services should they receive by videoconferencing?* How should videoconferencing services be monitored? Does the use of electronic devices like videoconferencing constitute health care practice? Does the video compression significantly alter the quality of images and data? Who should be liable if equipment fails or does not provide adequate information? Do more physical errors occur when videoconferencing technology is used rather than in-person assessments? Do consumers rights to privacy and dignity compromised by the use of videoconferencing? Should clinical practice guidelines or standards be developed for the practice of telemedicine? Which state laws should govern a videoconference encounter? What happens if a consumer has a bad outcome related to a videoconference consultation? Will malpractice insurers provide coverage for videoconferencing services? The paper will outline the progress that Queensland Health and New South Wales have undertaken in addressing the issues of confidentiality and efficacy in using videoconferencing in mental health services. Specific strategies outlined cover: standards, operational guidelines, duty of care, room setup, medical record retention, mandatory reporting, and informed consent. Queensland Health has developed comprehensive guidelines to scope the use of such technology. The document is called 'Clinical Practice Guidelines for use of Videoconferencing Technology in Queensland Mental Health Services, 1999'

181 Paper: CROSSING BOUNDARIES: CULTURALLY SENSITIVE PRACTICE IN THE ACUTE MENTAL HEALTH SETTING Theo Hastings, Gill Watson The growing trend in mental health service provision is a move away from intervention only with people with a diagnosed mental illness, to encompass people who have more general psychiatric complications stemming from external factors. The Ryde-Hunters Hill area has an extremely diverse population; a wide variety of ethnic and cultural groups are represented in this locale. Individuals and families from some of these groups have contact with the acute mental health service, and this contact has revealed that these people have often been subject to unpleasant experiences during migration to Australia or the settlement process. This paper aims to examine

how well community mental health workers are equipped to assess, empathise and work with migrants, many of whom have undergone torture and trauma in their countries of origin. Face-to-face or telephone contact with people from different cultures, in times of crisis, pose a number of challenges for community mental health workers, and many specialised skills are required in order to provide effective and appropriate intervention. This discussion will explore the skills required to work people from different cultural backgrounds in the acute mental health setting, including: Working with an anti-racist perspective Assessing our individual feelings towards different cultural groups, and avoiding the traps which a racist perspective creates. Having a grasp of the concepts of transference and counter-transference, and the effects of racism and prejudice on these. Providing objective and non-judgemental service. Cultural awareness The importance of a working knowledge of the cultures one is likely to work with, which includes a basic knowledge of political and social conditions in other regions. The concept of 'mental health' Understanding how 'mental health' is understood in different cultures, and being aware of how the practices of an "anglo-celtic" mental health service can impact on people from other cultures. Cultural sensitivity Employing culturally sensitive interviewing techniques, and understanding the potential effects of the interviewing process upon people who have experienced torture, trauma and upheaval in migration. Use of interpreters Understanding the appropriate use of interpreters in the interviewing process, and avoiding the common problem of the roles of interpreter and therapist becoming confused. Effective use of telephone interpreting services. Locating resources The importance of locating resources relevant and appropriate to different cultural groups both during and after normal business hours. Skills in advocating for clients to other agencies, and ensuring that there are clear lines of communication between all involved parties, and facilitating realistic expectations regarding outcomes. This discussion draws on our experience working on the Ryde Acute Mental Health Team, and is therefore guided by the clinical context and significant population groups of the area. The focus will be on working in the crisis setting, and with people with an Armenian or Iranian background; however, the principles and ideas raised can be translated to other settings and cultural groups, and we would argue, are vital for mental health workers in contemporary Australia

182 Paper: WHAT'S REALLY GOING ON HERE? DEVELOPING EARLY INTERVENTIONS INTO PSYCHOSIS. Jane Beckmann, Sean Halpin, Sian O'Brien, Vaughan Carr Can early intervention improve outcomes for young people who develop a psychotic illness? This is one of the questions that is currently being researched and debated. It has been suggested that intervening in the prodromal stage of a developing psychotic illness may prevent the illness becoming more biologically entrenched and help prevent psychosocial decline. If this is possible then it could offer hope to everyone. If it is not possible then knowing this will help us develop other intervention strategies. Developing a service for young people who may be at risk of psychosis presents many challenges. How do you encourage referrals, how do you engage the young person in what may to them be a potentially threatening situation, how do you assess who is and who is not at risk of psychosis, how would you treat a young person who is thought to be at risk, how can you avoid stigmatising the young person, how do you fit into a large comprehensive psychiatric service? These are many of the questions we have been considering for the last 3 years at the Psychological Assistance Service (PAS). PAS is one component of the Hunter Mental Health Service. PAS is a service designed to find and assist young people who may be at risk of developing a psychotic illness. Using a combination of literature review, statistical data and qualitative research we will present to you what we have learnt so far

183 Performance: TALL STORIES A SHOW ABOUT HEIGHT Gabrielle Macdonald Upstart Theatre was formed in 1992 by participants and workers at Prahran Mission. The group have produced three shows in 1992, 1994 and 1997 using conferences, community venues and in house facilities for performances. The shows have been created and performed by participants based on their experiences of mental health. The new show for Upstart is about height: exploring life's ups and downs, high risk situations on skyscrapers, people who are high handed or high minded and those who are tall poppies. The members of the group are finding out how highly strung, volatile and skilled they can be using real life experiences and humour. This thirty minute presentation, adapted from a full length show, will contain different people, different stories, different ways to tell a story. There will be a range of performance modes including art work, poetry, story telling, music and movement. The audience will gain insight into another way of seeing the world in a manner that is not dry and abstract but immediate and emotional. As each person has an individual experience of mental health and illness, it is important that these experiences are portrayed in various ways. This will be an opportunity for the audience to see how one group are

developing a method to creatively approach this issue. The audience can then take away these ideas to adapt for their own life and work.

184 Paper: THE SUTHERLAND DRIFT PROJECT   II: DEVELOPING A SERVICE MODEL
Lynne Hannan, Grant Sara, Lisa Woodland People with mental disorders are found in disproportionate numbers in the shelters, boarding houses and streets of disadvantaged inner-city areas. This is usually attributed to a process of socio-geographic drift, a combination of geographic movement and rapid socio-demographic decline. The associated problems of homelessness, eroded support networks and exposure to sometimes extreme adversity are well known. Less well known are the interactions between the individual's mental illness and this process of drift. This project assumes that negative interactions occur between these adversities and the evolution of illness, resulting in severe but preventable secondary deficits. We have previously seen evidence of such drift within two years of a first episode of psychosis (THEMHS Conference 1997). This paper will describe the continued work of this "Drift Project" in developing a service which can detect and prevent psychosocial drift. We have drawn on recent interventions with homeless youth which suggest that a combination of vulnerable tenancies and poorly managed interpersonal conflict lie at the heart of breakdown in social networks. Successful interventions based on this approach have not been systematically tried in mental health settings. The project targets two vulnerable groups. Firstly, those experiencing interpersonal conflict where it may be possible to preserve vulnerable tenancies and social networks. Secondly, those who have recently "drifted", who are often poorly served by conventional service models which discourage assertive outreach or collaboration across service boundaries. Elements of the service model which will be discussed include (1) application of a mediation/conflict resolution approach in family relations work within a mental health service, (2) development of cross boundary models of intervention including "tracking", assertive outreach, and collaborative co-case management of an individual and their family, and (3) the development of partnerships to increase respite and "time-out" accommodation options in the Sutherland Shire

185 Paper: SMOKING CESSATION IN SCHIZOPHRENIA Kathryn Strasser Despite a significant decline in smoking in the general population, the rate of smoking in people with schizophrenia remains disturbingly high (up to 90%). It has been recognised that smoking cessation in these people is complicated by the pharmacological effects of smoking on symptoms of schizophrenia and depression, and on medication doses and side effects. SANE Australia, in collaboration with the University of Melbourne Department of Psychiatry, are piloting an intervention aimed at assisting smoking cessation in people with schizophrenia. The intervention comprises patients being regularly reviewed by their general practitioner, assisted by clinical guidelines prepared for this project. They will also attend a series of Quit Smoking group sessions, especially designed to take into account the cognitive, affective and social difficulties these people may have as a result of their mental illness. The guidelines for the general practitioners include recommendations regarding initial assessment and management of the patient prior to smoking cessation, followed by regular monitoring of the effect of smoking reduction on the patient's mental state. This is important in view of the risk of relapse of schizophrenia or onset of depression, or the need to alter psychotropic medication doses. The intervention will be trialed in a region with a well established GP shared care program where psychiatric assistance is readily available. Details of the intervention will be described and initial results presented

186 Paper: SECLUSION: WHOSE REALITY? Christine Palmer, Marnie Newey, Vicki Burnett. Seclusion involves placing someone in a small, almost bare room, usually without bathroom facilities, and locking the door. This practice is variously described as therapeutic through to punitive. It is well documented that nurses are more concerned with maintaining order on the ward rather than interacting in a therapeutic fashion with clients. And, despite moves toward adopting the least restrictive alternative in caring for people with mental illness, seclusion episode rates remain high. The reasons for this are complex. One reason is the difference in perception of the therapeutic effects of seclusion between staff and consumers. Consumers have consistently reported the negative impacts outweighing the benefits of seclusion while staff consider seclusion a therapeutic intervention. This paper reports the findings of a pilot study designed to clarify the viewpoints of consumers in one health service. It reports the results of a focus group interview with a small group of consumers who experienced seclusion during the previous 12 month period. The consumer's view of reality is sought to determine the experience of seclusion in the time prior to, during, and following a seclusion episode. Do consumers experience benefits from seclusion? If so, what are they? Also, feedback will be provided regarding what alternative interventions might have been more helpful for the person prior to or at the time of seclusion. This study is part of a wider exploration of seclusion practices within Waitemata Health Mental Health Services in Auckland, New Zealand

187 Paper: "ZERO WAITING LIST" Allan Mawdsley Alfred Child and Adolescent Mental Health Service community-based outpatient clinic has been successfully operating a zero waiting list policy for the last two years. In 1998 our 29 EFT staff assessed and treated 729 new referrals, and continued treatment of a further 498 cases which had first been registered in earlier years. This total of 1227 patients received 17,552 direct service contacts averaging one hour in duration. For every hour of direct contact there was a further hour of patient-related activity such as casefile documentation, phonecalls, school visits, meetings, etc. The remaining employment time was occupied by Community work, professional development, and a variety of non-patient related administrative tasks. A full-time Intake Coordinator screens requests and allocates accepted referrals to appropriate staff members in rotation. The first appointment time for elective referrals is within one week of contact, or same day for crisis calls. Appointments are offered by the Intake Coordinator on behalf of the staff member at times reserved for that purpose. Implementation of this policy took considerable planning based upon an analysis of work patterns and existing obligations. The method will be described in the presentation. Although this approach was implemented in a CAMHS clinic which characteristically has a very time-intensive treatment requirement, the methodology would be applicable to a wide variety of clinical treatment schedules.

188 Paper: EXPLORATORY STUDY OF GP ATTITUDES TO PSYCHIATRIC SERVICES IN SOUTHWEST VICTORIA D Chinnasamy In early 1998, as a first step to improving liaison and strengthening relationships with general practitioners (GPs), Warrnambool and District Base Hospital Psychiatric Services Division (PSD) conducted a study of the needs and experiences of general practitioners regarding both their own provision of mental health care, and the joint provision with PSD. 85 GPs operating from 35 medical practices servicing a population of approximately 100, 000 were asked to meet the new Director of Psychiatric Services, and to complete a five-item questionnaire. The DCS met 55 GPs in their private practices and 47 questionnaires were completed. The informal discussion forum was useful in extracting fundamental, core issues for GPs, while the questionnaire responses served as a useful adjunct to discussion results and gave a measure of GP attitudes to five issues :PSD's treatment of their referrals. GPs' own management of their patients   PSD's case management of their shared clients. GPs' knowledge of other support services. PSD's specialist staff accessibility. The findings of the study show that while GPs acknowledge that many aspects of PSD have improved, particularly in the 2 years prior, there are still some outstanding issues. Many GPs are adjusting to the single-point of entry to WPS, via a nurse or allied-health professional, and feel that the process is unnecessarily time-consuming, particularly after hours, and would prefer access to psychiatrists in acute situations. GPs acknowledge that they require education and access to specialist consultation, particularly for the management of their more difficult patients ineligible for PSD case management. They also consider open communication channels with PSD important in ensuring optimal shared care, as they do accessibility to specialist staff, particularly consultant psychiatrists. GPs rate their knowledge of other community supports poor, while recognising the support they are able to offer. In conclusion, GPs acknowledge that their involvement with mental health management and services has and will necessarily continue to increase. They are however, making it clear that in order to take on their increased responsibilities, they require improvement in their knowledge and skills, and to be able to confidently rely on PSD for going and practical consultative support.

189 Paper: COMMUNITY PSYCHIATRIC PERSONNEL ATTITUDES TO GP ROLES D Chinnasamy In March 1998, 39 (66%) of Warrnambool & District Base Hospital Psychiatric Services Division (PSD) clinical therapists were interviewed on their attitudes to and experiences with GPs' involvement with shared clients. They were also asked to complete a questionnaire which described their current practices and involvement with GPs. This study and a parallel study of GP attitudes, sought to illustrate the current GP / PSD relationship from which initiatives for improvement could be taken. Clinicians reported that considerable variation in appropriateness of GP referrals existed, with the aged persons' team (APMHS) expressing greatest satisfaction. For 26 % of clinicians, further information was sought from the GP at referral often or routinely. Clinicians suggested that closer GP involvement with PSD in shared care would serve an educative purpose for GPs. The only topics nominated by clinicians for formal GP education were for risk assessment, and the PSD model of care. Questionnaires indicated that clinicians and GPs rarely met in person, but that informal telephone discussions occur routinely or more than occasionally for over half of clinicians. Clinicians indicated that their motivation to contact GPs was diminished if they were consistently difficult to access. Clinicians indicated that GP involvement in shared care arrangements was more likely for those accepting of the PSD model of care, and that greater GP involvement was generally desirable and beneficial to their clients. 84% of clinicians encouraged their clients to use their GP for prescribing routinely or often, and 73% encouraged their clients to find a GP if

they did not have one. Clinicians reported that they assisted GPs in improving their knowledge of other appropriate support services by providing them with thorough onward referral advice and case closures. Clinicians accepted the need for GPs to consult directly with psychiatrists. They indicated that the level of adjustment to the single point of entry varied amongst GPs. 50% of clinicians reported that GPs requested to speak directly to a psychiatrist occasionally or more often. 13% of clinicians reported conflict with a GP over a referral more often than occasionally. Clinicians viewed professionalism, good outcomes for their clients, and time as important factors in the development of improved working relationships with GPs.

190 Paper: FOLLOW-UP STUDY OF GP ATTITUDES TO PSYCHIATRIC SERVICES IN SOUTHWEST VICTORIA D Chinasamy In March of 1998 and then one year later, general practitioners (GPs) in southwest Victoria were issued with a 5-item questionnaire which asked them to rate their satisfaction with aspects of Warrnambool & District Base Hospital Psychiatric Services Division (PSD) and their own management of their mentally ill. They were also asked to list any issues that they felt ought to be addressed in order to improve the current working relationship with PSD. This study was undertaken to determine what changes had occurred in GP attitudes since the start of a GP Liaison Project in 1998. The Project's direction was influenced by an exploratory study. Its main findings showed that GPs were frustrated with the single point of entry - particularly after hours, that they wanted greater access to psychiatrists, that practical consultative support for GPs was important, that two way communications needed improvement, and that their skills and knowledge required upgrading as did their knowledge of other support services. As a direct response, over the course of the year PSD introduced a policy of localised after hours emergency services, organised regular GP education, increased the accessibility of psychiatrists and clinical therapists and improved the quality of feedback to GPs. The 1999 questionnaire responses indicate that GPs are more satisfied with the handling of their referrals by PSD, as they are with PSD's accessibility. They are however, less satisfied with both their own management of their mentally ill patients and with PSD's case management of their shared patients, while their knowledge of other community supports remains unchanged. GPs still consider access to psychiatrists important, as they do effective communication. Whilst GPs have indicated that PSD is more responsive to their requests for specialist staff access and assessments at referrals, the need for practical support in the ongoing management of their mentally ill patients, whether case managed by PSD or by the GP is clearly the most important issue that PSD now needs to address if it is to continue to improve the working relationship with GPs

191 Paper: THE PSYCHOSIS AND SUBSTANCE USE PROJECT Nandi Siegfried, Since July 1997 the Central Sydney Area Health Mental Health and Drug and Alcohol Services have been working closely together on the Psychosis and Substance Use Project. The principal aim of this Project is to develop a strategy that will best meet the needs of those people with comorbid psychotic illness and problematic drug and alcohol use living in Central Sydney. The Project has worked within the framework of the three key themes of the renewed National Mental Health Strategy viz. prevention; partnerships in service reform; and quality and effectiveness. This paper will outline the stated objectives of the 2 year Project and describe actions taken to achieve these objectives. Outcomes attributable to the Project will be described in more detail and their relationship to the themes of the National Mental Health Strategy identified. Outcomes to be described include: The establishment of a Special Interest Group of key stakeholders to inform and advise the Project The conduction of a needs analysis regarding service provision - this comprised a staff survey, consumer focus groups and an appraisal of information systems Development of an educational workshop for consumers and mental health staff from both the government and non-government sectors Working in partnership with non-government organisations to expand and improve the delivery of services to young people with mental health and drug and alcohol problems Development of a consumer information leaflet about drugs and mental health Establishment of a management structure to support the above initiatives Evaluation of the Project and associated initiatives In addition the recommendations arising from the Project for a continued response from Central Sydney Area Health Service to the needs of people with both mental health and drug and alcohol problems, will be described

192: Paper: SIMPLE DESIRES ATTRACT COMPLEX RESPONSES.INTEGRATED RURAL MENTAL HEALTH SERVICES ON THE EAST COAST OF NEW ZEALAND Rose Kahaki, Julia Carr The East Coast Mental Health Service shares its story of development from the "wonder if" s to the reality of a comprehensive, rural mental health service for an isolated, predominantly Maori population in New Zealand. The service has grown from a satellite 'hostel' of the urban hospital to a community based service owned and operated by Ngati Porou. It is becoming unusual in New Zealand for one provider to offer an integrated range of services such as key workers providing 24 hour, community based care,

specialist clinics, meaningful activity, dual diagnosis support, counselling, drug and alcohol assessment, respite care, residential care, crisis support, early intervention for youth, primary care liaison and advocacy. An innovative aspect of this service is the employment of a full-time client advocate whose role is to foster consumer, family and community participation and support the maintenance of culturally appropriate practices. Employment of consumers and an active approach to community education, early intervention and destigmatisation are also features. Although the service was born of a desire to meet local needs inappropriate ways and based on the shared vision of local staff and community, the outcome is a service which conforms to the Assertive Community Treatment model and best practice internationally. This is reflected in markedly decreased rates of hospitalisation and improved levels of functioning for clients with chronic illness. The contracting issues for a small rural service in a purchasing environment based on urban models, national prices and competitive ,fragmented services are discussed.

193 Paper: PROMOTING CONSUMER PARTICIPATION AS MENTAL HEALTH RESEARCHERS Lindsay Oades, Linda Viney, Esther Wong, Chris Bowker, Jon Strang This paper suggests that appropriate research may provide a voice for consumers in contrast to traditional research which can be seen as exploitative and irrelevant to mental health consumers. After providing recent examples of successful consumer involvement in mental health services, this paper explores how consumers can constructively participate as mental health researchers. A selection of research methodologies and models that promote collaboration between consumers and established researchers are described. These approaches include focus groups, action research, co-operative inquiry, diary, narrative, phenomenological and feminist methodologies. These approaches, often but not necessarily qualitative, are rigorous yet collaborative and egalitarian, and their assumptions provide a contrast to many assumptions underpinning traditional research methodologies. In the final section of the paper specific guidelines are provided to promote consumer participation as mental health researchers. Barriers to this aim and possible ways to overcome these barriers are discussed

194 Workshop: COLLABORATION IN SERVICE DELIVERY. DEALING WITH THE REALITY OF COMPETITION. David Clarke Overview This presentation will examine the application of competition policy in human services, and it's effect on service and policy development within mental health services, as well as between mental health services and other related sectors such as drug and alcohol, and other primary health services. Aims/educational objectives It will be articulated how the application of competition policy on mental health service delivery is creating serious problems with mental health policy and service development, and how these problems will impact on service quality for years to come. Areas covered will include: Changing approaches to policy development and service sector consultative processes; New relationships between service providers - a move from collaboration and information sharing to competition; Corporatisation of health providers and community organisations, creating changed strategic focus within organisations - generating a move by organisations away from social objectives to organisational objectives The presentation will present the findings of "The Cornerstone Project" - an 18 month VICSERV project which has examined and transformed linkages and collaborative relationships between clinical mental health and community psychiatric disability support services. A series of strategies will be presented which outline ways in which services and whole service systems can work effectively together in a competitive human services environment. These strategies will outline the roles of direct care/support workers, program managers, and senior managers within mental health services. Overall, we will be presenting the message that collaboration and service development can occur in a competitive environment, with the right intent, the appropriate strategies, and a commitment from key stakeholders

195 Workshop: THE INTERNET - INFORMATION, COMMUNICATION, FANTASY AND REALITY.David Clarke, Colin Brokenshine Overview This workshop will examine the use of the Internet as a tool for service users and service providers in mental health services. Aims/educational objectives We will examine the outcomes of the VICSERV "NetNation project", which has brought more than 1000 people with a psychiatric disability on-line onto the Internet through psychosocial rehabilitation day programs in Victoria, and how we can apply what we have learnt to mental health services broadly. Project outcomes will be presented, both positive and negative. The issues examined will include: The role of the Internet in informing consumers; The role of the Internet in informing mental health staff on health, service and related issues; using the Internet to provide opportunities for communication - chat lines - enhancing or limiting communication ?; mailing lists - what are they good for ?; access to information - a powerful tool for consumers and health professionals or a cacophony of questionable data?;We are also seeking, through this presentation, to de-mystify many aspects of the Internet, and demonstrate that with

minimal computer skills, people can access a range of products and sites. We propose that the workshop include live hookup to the Internet, utilising a large screen for the audience, with a number of sites, mailing lists and chat forum around the world accessed. Audience members will be used during the workshop to navigate the World Wide Web and chat sites, advised by VICSERV infotech staff. If assistance is required to facilitate internet connection, VICSERV can provide this assistance

196 Paper: THE REALITIES OF CLINICAL / DISABILITY SUPPORT COLLABORATION AND PROTOCOL DEVELOPMENT Gary Humphry, Janet Punch This presentation aims to showcase the protocol between Warrnambool and District Base Hospital Psychiatric Services Division, and the Association for Support of Psychiatric Services Inc. The protocol enables the two services to operate collaboratively, despite the differing mandates and philosophical approaches of both services. The south west of Victoria covers some 24,500 square kilometers and supports a population of over 100,000. The clinical service (PSD), and the non government disability support service (ASPS) both have staff employed and living in outlying centres. Working in small rural towns has enhanced the good collaborative relationship built between clinical and disability support staff, and has allowed a dialogue to inform ongoing service provision. It provides an excellent opportunity to 'tease out' the intricacies of agency protocol. Protocols were prepared in 1997 by both services to enhance the working relationship. These protocols were found to require review and change in 1998-99, as both agencies interpreted parts of the document differently. As ASPS and PSD are changing organisations, the protocol has required constant review. The process for review involves the input of both agencies, carers and consumers. The protocol has evolved into a useful working document, which will require ongoing review to ensure it remains a working document. The aims of the presentation will be as follows: To provide an overview of how the protocol was developed To acknowledge and publicly describe the challenges To provoke discussion and questions To express professional values, philosophies and emotions To educate and expand conference participant's knowledge base To provide services with working resources within rural environments To explore professional consumer driven dreams and realities regarding collaborative service provision

197 Workshop: WORKLOADS MEASUREMENT IN PSYCHIATRIC DISABILITY SUPPORT SERVICES John Dutton, Gary Humphrys Psychiatric Disability Support Services provide unique challenges regarding the setting of manageable workloads. Consumer support requirements may fluctuate markedly during the time they engage with the support service, and worker responses are varied by a range of program imperatives, from group activity to one on one support. This workshop will show how a workload measurement system was implemented in a rural Psychiatric Disability Support Service (Association for Support of Psychiatric Services Inc.), and how this tool is used to monitor staff workloads in a manner which enhances collaboration and work sharing. It was implemented October 1998, and is in a process of refinement and adaptation. The tool uses the underlying principles of: Transparency. Workers are aware of each other's case loads Empowerment. Workers may change the system by agreement Flexibility. Reasonable workload levels are determined by worker feedback. The system measures the secondary activities of workers, such as administration, supervision, meetings and training, adds the inflexible blocks of activity (in this case 'group activities'), and then uses a points system for low, medium and high levels of support to gain a 'workload ratio. 'The workshop will show how the system was developed, and how it was changed in practice. Participants will be able to apply the system in varied environments

198 Paper: CONSUMER DRIVEN SERVICE DEVELOPMENT IN SMALL RURAL COMMUNITIES Chris Parsons, Riitta Giles STATEMENT The Association for Support of Psychiatric Services Inc is a non-government community based organisation providing outreach support and information to rural consumers and carers. It is individually focused, consumer driven and provides a strong community development focus. This has led to diversity in the delivery of services in the smaller rural communities within the catchment area. INTRODUCTION ASPS provide a unique service. The organisation was established in 1989 with the aim to address the support needs of consumers and carers in the southwest Victoria through empowering consumers, carers and communities. In 1996 support services were established for individuals with a psychiatric disability. Initially the service was developed in Warrnambool and was shortly followed by Portland, Hamilton and Camperdown. AIMS OF THE PAPER To outline how ASPS provides a comprehensive service driven by consumers and focussing on the community. To illustrate the diversity of service delivery in small rural communities. Service users in Portland and Hamilton have created unique programs in these communities. To discuss how consumer support is provided based on individual needs and how this impacts on the direction of service development. To outline ASPS commitment to community access which involves community development,

referral and advocacy, with the aim to facilitate access and participation in community activities, services and social and recreational networks. To stress that work with generic services and communities is an essential element in the development of access and support within the community

199 Workshop: MENTAL ILLNESS EDUCATION AUSTRALIA - A SCHOOL BASED MENTAL ILLNESS EDUCATION PROGRAM Kim Freeman, Janette Scott The primary aim of this workshop is to introduce to the audience an innovative secondary school based mental illness education program that has been developed by a national non-government organisation which is being delivered in schools across Australia by classroom presenters who have a personal experience of mental illness. The Mental Illness Education Australia School Education Program aims to educate young people in schools about mental illness. The program has been developed to counter the mythology and prejudice surrounding mental illness and to increase the awareness amongst young people of mental illness and mental health issues in relation to themselves, their families and friends. This workshop will clearly demonstrate how this innovative, nationally recognised Program can be transferred and delivered into any community or region throughout Australia, particularly in the context of the National Mental Health Strategy second stage of promotion and prevention of mental illness. To date the School Education Program has been presented in hundreds of classroom to thousands of secondary school students across Australia since its inception in 1987.The workshop will include an introduction of the MIE-A Education Program by members of Mental Illness Education Victoria team followed by a classroom presentation delivered by accredited MIE-A classroom presenters who are carers and consumers

200 Paper: STAFF SUPPORT AND TEAMWORK Sue Cox, Debbie Hocking, Jax Roan, Kathy Higris **A bridge to quality service delivery in psychiatric disability support Staff support and teamwork is crucial to the delivery of a high quality service in a psycho social rehabilitation setting. his paper will attempt to show how staff can provide a high quality service which encompasses the principles of psycho social rehabilitation while working with severely abused clients who often present as angry, blaming of others, demoralised and unmotivated. Effective staff support mechanisms, formal and informal are part of the answer. An organization demonstrates commitment to staff by providing quality supervision, effective team building processes and formal peer support. However, informal support and team processes can play an important role. Aspects that will be discussed in this paper include: The role of the team, including team work, work practice and reflection and development of responsibility for self The role of the program manager Development of a safe learning environment Western notions of individualism as opposed to mutual support Development of a leadership role for all team members The role of debriefing Working in the Mental Health System and its impact on staff We will explore the advantages and disadvantages of our approach and discuss aspects that have worked and those that have been less successful. Finally we will attempt to draw some conclusions from the lessons of our experience. The material for this paper will be drawn mainly from our experience of service delivery at Yandina, a program of the Richmond Fellowship of Victoria. Our primary goal at Yandina is to create and maintain a supportive, inclusive residential community fostering psychosocial rehabilitation of homeless adults with complex needs. Yandina also provides outreach support to former residents. The program has proven beneficial for people who have found more traditional, mainstream accommodation of support services inappropriate, or have been excluded because of behavioural issues.**

201 CHILDBIRTH AND MENTAL HEALTH: OUTCOMES FROM A QUALITY IMPROVEMENT PROJECT Rebecca Reay Aims of paper: To raise awareness of the range of childbirth related mental health problems and their impact on society To outline a process for involving stakeholders in the design of an improved model of care To highlight key system issues in perinatal mental health requiring improvement Present the implementation and evaluation stages of the project. There is increasing evidence from epidemiological studies that the first 12 months postpartum represents the greatest risk of psychiatric illness in a woman's life (Brandon, 1982). The risk of depression is increased by three fold and the risk for a psychotic illness is increased 25 fold for the first 25 days, remaining raised for at least the next two years. Postnatal depression has also been associated with increased rates of marital conflict, child neglect, child abuse and childhood behaviour problems (Stein et al 1991, Rutter 1984). Furthermore, longitudinal studies of the impact of postnatal depression on preschool and school age children have consistently reported a variety of adverse effects including, raised levels of psychiatric disturbance, greater insecurity in attachment relationships, impairments in attention and lowered IQ (Weissman et al, 1984; Cohler et al, 1977; and Cox et al, 1987). These findings provide strong arguments for the development of screening programs, early detection of 'at risk' clients and evaluation of effective

methods of treatment within the health service. The ACT Mental Health Service sought to improve the delivery of services to families affected by childbirth related mental health problems. A project was developed which involved a process of extensive consultation with consumers, mental health professionals, academics other service providers. A new model of care was developed and is coordinated by a steering committee which oversees the project. A system of monitoring the new model was devised and the success of the project is being evaluated using both process and outcome evaluations. The findings reveal that a quality improvement process is an effective method for making continuous improvements to a health care system

202 Paper: LOOKING THROUGH THE INFINITY LOOP:THE CHALLENGE OF EXTENDED AND LONG TERM MENTAL HEALTH CARE Joy Pennock, Julie Jackson,Lisa Woodland, The aim of this paper is to discuss the question "How can the needs of consumers with long term mental illness be addressed across the lifespan within the context of limited mental health resources? "Mental health services are increasingly required to balance the needs of consumers with long term support needs and their carers with new initiatives which emphasise prevention and early intervention, often without a commensurate increase in resources. The Extended Care and Long Term Support Project, conducted by the Sutherland Division of Mental Health, examined the long term care issues within a local mental health service. Service use information and other data were collected for 75% of all active community consumers. Consultation sessions with consumers and carers were also conducted. Results indicated that:1. Patterns of service for long-term consumers use tend to remain static over time regardless of changing circumstances. 2. One of the most significant areas of need, consistently reported by consumers and carers, was the disadvantage experienced by consumers in the community. The implications of these results are far reaching. A significant number of consumers and carers will continue to need extended care and other ongoing support in the immediate future. The need to re-evaluate clinical practice in relation to long term care is therefore paramount. Additionally, reappraisal of the role of mental health services in addressing disadvantage requires careful thought. A local strategy developed by the Sutherland Division of Mental Health is discussed and future challenges for all mental health services are highlighted.

203 Paper: THE SUTHERLAND ACCESS PROJECT: INVESTING IN THE FUTURE OF THE COMMUNITY Greg Norton-Baker, Grant Sara, Kerrie Gill, Evelyn Chandler, Lisa Woodland One of the greatest challenges to integrated hospital and community based Mental Health services is to provide an accessible and equitable service to the community it serves. The aim of this paper is to discuss how the issue of access has been addressed by the Sutherland Division of Mental Health through the Access Project. During 1998, a needs assessment was conducted by the Division, drawing upon referral data from the previous 12 months and consultation sessions with existing consumers and carers of the service. The results of this needs assessment will be presented along with implications for working in collaboration with GPs and other service providers. The results of the needs assessment were used to inform the Access Project. The objectives of the project are:(1) to increase the access of community members to mental health service providers (2) to provide a single point of entry into the Division of Mental Health Organisational change strategies used to implement this project will be discussed along with the challenges of ensuring effective engagement and collaboration with all stakeholders

204 Paper: THE SUTHERLAND DRIFT PROJECT II: DEVELOPING A SERVICE MODEL Lynne Hannan, Grant Sara, Lisa Woodland People with mental disorders are found in disproportionate numbers in the shelters, boarding houses and streets of disadvantaged inner-city areas. This is usually attributed to a process of sociogeographic drift, a combination of geographic movement with rapid sociodemographic decline. The associated problems of homelessness, eroded support networks and exposure to sometimes extreme adversity are well known. Less well known are the interactions between the individual's mental illness and this process of drift. This project assumes that negative interactions occur between these adversities and the evolution of illness, resulting in severe but preventable secondary deficits. We have previously seen evidence of such drift within two years of a first episode of psychosis (THEMHS Conference 1997). This paper will describe the continued work of this "Drift Project" in developing a service which can detect and prevent psychosocial drift. We have drawn on recent interventions with homeless youth which suggest that a combination of vulnerable tenancies and poorly managed interpersonal conflict lie at the heart of breakdown in social networks. Successful interventions based on this approach have not been systematically tried in mental health settings. The project targets two vulnerable groups. Firstly, those experiencing interpersonal conflict where it may be possible to preserve vulnerable tenancies and social networks. Secondly, those who have recently "drifted", who are often poorly served by conventional service models which discourage assertive outreach or collaboration across

service boundaries. Elements of the service model which will be discussed include (1) application of a mediation/conflict resolution approach in family relations work within a mental health service, (2) development of cross boundary models of intervention including "tracking", assertive outreach, and collaborative co-case management of an individual and their family, and (3) the development of partnerships to increase respite and "time-out" accommodation options in the Sutherland Shire

205 Paper: DEVELOPING PARTNERSHIPS - AN INTERSECTORAL ACTION APPROACH TOWARDS SETTING UP A SOCIAL CLUB Angela Siggens, Kerrie Gill,Rodrigo Gutierrez, One of the greatest hurdles for most people recovering from a mental illness, beyond overcoming the actual symptoms of the illness, is also to rebuild a social life and return to participation in meaningful daily activities. For most people, these things, which are central to our sense of self and our need to belong, are generated through employment, family, social networks and leisure interests. For people living with a mental illness however, there are many barriers that can limit opportunities in these areas. In the Sutherland Shire, an area south of Sydney, a collaborative partnership has been created between the Mental Health Service, St. Vincent de Paul, carers and consumers, to address the social and leisure needs of consumers living with a mental illness. The project aims to set up a Social Club that acts as a venue for a drop in centre and facilitates a program of consumer run activities and events. One of the keys to the success of this project will be in its sustainability in the community. Using an intersectoral action framework to describe the development of the project, this paper aims to highlight some of the potential pitfalls and indicators for success along the way. Key stages in the history of the project will be described including the cultural and organisational changes involved in transforming a Mental Health Service run Living Skills and Day Program to a consumer driven, community based Social Club

206 Paper: WHOSE DREAMS? WHOSE REALITIES?OUTCOME STUDY OF CHILDREN AND ADOLESCENTS WITH PERSISTENT CONDUCT PROBLEM PRESENTING TO CHILD AND ADOLESCENT MENTAL HEALTH SERVICES Ernest Luk, Petra Staiger, John Mathai, Lisa Wong, Peter Birleson, Robert Adler Objective: More information about outcome is needed in child and adolescent mental health service (CAMHS) as highlighted by the National Mental Health Strategy. Method: We examined the outcomes of 46 children with persistent conduct problems by gathering at base-line and six months information from multiple informants on multiple domains including the functioning of the child, risk factors, and parents and children's perception of the treatment process. Results: A significant reduction of oppositional / conduct symptoms was reported 6 months after the initial clinical contact. However the majority of the group still scored within the clinical range. The improvement rate according to the parents and clinicians were 37% and 43% respectively. The various outcome measures are only correlated to a mild to moderate degree. Teachers did not notice the same degree of change at school, despite the changes noticed by parents. Symptom improvement and satisfaction of a service are two separate issues. Parents' satisfaction was related to their perception of the therapist and the therapy offered. Their satisfaction was high if they perceived the therapist was able to communicate well, showed care and concern and if the therapy was perceived as organised. Conclusion: The current management of this clinical group needs improvement. Outcome measures should cover multiple informants. Symptom improvement and satisfaction of a service need to be assessed separately

207 Paper: BELCONNEN COMMUNITY CENTRE SHAKES ACT AN OVERVIEW OF THE TWO ACCESS PROGRAMS BELCONNEN LEISURE PROGRAM AND BELCONNEN OPEN ART EXPLORING HOW THEY ARE LINKING THE MENTAL HEALTH SECTOR AND COMMUNITY SERVICES Sam Moskwa, Sally Paterson, Lorna Crane, Tracey Thomson Over sixty people with a range of mental health disorders, are active at Belconnen Community Centre and in the Canberra community through participation in two new, community access programs known as Belconnen Leisure Program (BLP) and Belconnen Open Art (BOA). BLP is a Belconnen Community Service Program funded by our health promotion statutory body, Healthpact and BOA is funded by ACT Mental Health Services. Activity and sports subsidies are available and there is no referral requirement to either program. BLP supports participation in centre activities in arts, recreation, sport, and education areas and in local and interstate sport teams. BOA provides the opportunity for participation in integrated arts classes and projects. Participation in both programs enables health, friendships and self confidence. BLP's coordinator supports people with information about activities, personal skills, confidence and transport. She also coordinates a new outdoors program which supports people who are 35 years and under, to participate in sport teams in the NSW sports competition. Teams for volleyball, badminton and a ten-pin bowling have been established and this year two teams will compete in NSW. The programs have a strong, community and government education role. While participants learn access and activity skills, other group

members, caseworkers, staff, tutors and GPs are learning mental health literacy skills. Both programs are providing a role model for other community facilities and have influenced ACT MHS to examine options for healthcare management in the community settings. The paper will outline the vital role of community based access programs in the maintenance of good mental health and the health benefits for the whole community. It will highlight the vitality of community participation, the strengths of collaborative projects and the difficulty of obtaining ongoing program funding. We will use a video tape and slides

208 Paper: ITALIAN MENTAL HEALTH CARERS SUPPORT GROUP.FOCUSING ON THE CUSTOMERS POTENCIAL. Carmine DiCampli, Biagio Sirgiovanni The Transclutural Mental Health Centres Italian Sub-committee currently has, as active members, some workers that have provided or developed self support group structures to the Australian Italians in the Sydney metropolitan area over the last 10 years. During this time, while the original worker was active as the facilitator, all groups were successful. But, whenever the worker either left the position or had to withdraw from the program, it eventually failed. To us it is clear there is a strong need amongst the Australian Italians to develop dependant relationships with health care professional.The myth that the service providers have extra knowledge in regard to caring for issues relating to health is very strong. We explored weather it is connected to the migration process .On several occasions, in our practice of group psycho education, members attended in the hope of attaining knowledge, security, protection and nourishment by what they perceive to be an omniscient leader. The way group members participated, a dependency culture develops. On every occasion a support group was established, as long as the professional was present, members obtained a vicarious sense of power validation and strength. But when he/she left the group, a sense of disappointment, anger and powerlessness again took over and reinforced a negative perception of themselves in the group. They felt doubly disempowered. During the migration process there is clearly a move from a sense mastery to a state of disempowerment. This particular mind set develops also as far as health issues are concerned, "the health professional holds all the competence, I depend on him". The previous sense of competence one had in the country and culture of origin is some how perceived as not useable in the new context. We, as health professionals, felt that in our provision of the service, we inadvertently validated this myth. It is therefore our aim to start from the experience of the participants, not the knowledge of the expert. *Experience is knowledge.* We don't have a performed model, but instead are allowing the group to evolve and we as professionals are placing ourselves in a position where we are guided by what people bring to the groups. What is of paramount importance is how people choose to use the time and space in the group Initially the group had low attendance because the 'experts' refused to allow the dependency culture to occur. There was disappointment because they wanted to "learn and be guided". But after the 'original shock' members are know accepting that, whenever they bring their personal experience, they bring what is most important and valid in the group. They don't need 'the experts', instead the experts are seen more as resourceful participants. Health professionals work in partnership with group members. Whenever the group members talk about mental health issues through stories, they become the most competent people in the field. They bring meaning to it. The expert is the owner of the story.By not allowing the dependence to occur there has been a shift, we don't know where it will lead or what it is, but it is definitely not dependency. Questions about the use of group space are crucial. Attempts are continually made by participants to re-establish the dependency relationship. The facilitators have had to be alert to this consideration constantly. This philosophy has been challenging to us as health professionals because it works aganist all previous models where we were the "experts". Instead we now see our role as enhancing the sense of competency that already exists in the group. There is now considerable energy invested in the group by the participants so that it continues to exist. At this point, if the group were to lose its facilitators, the old pattern of invalidation would not continue to occur

209 Performance: RICHMOND FELLOWSHIP OF VICTORIA Sally Bilbao We aim to present a musical/drama theatre production that intends to illustrate and outline the process of thoughts, feelings and actions that are experienced by various groups when establishing a new psychosocial residential rehabilitation program for young people in the community. The outline of the performance will include several versions of the same process as experienced by the different groups represented. The cast of performers will portray the story throughout a series of acts. Act one will include an historical perspective outlining how the Department of Human services have responded to the need for psychiatric services for young people stated by the general community. This lead to the tender process to explore models for the development of services that could meet those needs. Act two will include the Richmond Fellowship of Victoria being the organisation that is selected to develop, set up and run a residential rehabilitation program for young people. This act will include the organisations' vision of what the program can offer to

young people, in order to provide opportunities for a more positive and hopeful future. Act three will include the local community- introducing the new program to the local neighbourhood. This will include their perceptions of the new program, their fantasies of what it could be and how their vision of their local neighbourhood will be affected due to the introduction of the new program. Act four will include the experience of the young people who are moving in to the program. Incorporating their visions of what the program means for them, emphasising the importance of establishing the translation of their vision in to reality. Establishing a place to call home, a place of belonging, a place of growth and change and opportunities for a more hopeful future. The performance will also portray the interactions between the groups, highlighting the overt and covert communication, the dynamics occurring between and within the groups. Our wish is to depict all the elements of the process, including the excitement, energy, enthusiasm and mutual benefits. Whilst also presenting the struggles, fear, barriers, uncertainty and challenges in the face of change. Using music and drama as a medium to tell the story we hope that a meaningful learning experience will occur for all delegates. The performance will include different characters portraying the covert messages; we will also have shadow performers that speak to the unconscious dynamic. The end of the performance will conclude with a portrayal of all the groups working through the process to a healthy resolution.

210 Paper: COMMUNITY TEAMS TO INTERDISCIPLINARY TEAMS Janet Austin Care of those with mental illness has undergone significant change over the past ten years. Treatment once supplied in an institutional setting is now provided in the community. Resources have been redirected away from infrastructure into the provision of sevices within the community. The initial focus of community based mental health care provided medication compliance, contact with psychiatric staff and hospitalisation where necessary. Over the next few years the quality of care developed further with the emphasis on multidisciplinary teams offering different perspectives on the treatment provided to those with mental illness. As well as including multidisciplinary teams within the treating teams, the Warrnambool Psychiatric Service has accepted the Integrated Model of Mental Health Care which guides the structure of treatment provided. Clinical therapists within the Service receive training in core competency skills including assessment of the presenting problem, assessing clients' needs, mental state examination, and risk assessment and management. As well as maintaining core competency skills, clinical therapists are further enhancing the efficacy of the teams' work by using discipline specific techniques in their daily work. of each client. As each team draws more heavily on the discipline specific training of clinical therapists, the efficacy of the service in providing quality care to clients and families in the community continues to improve. This paper focuses on the discipline specific training and techniques that are being used in the interdisciplinary teams to provide a higher level of assessment and treatment to those with mental illness.

211 Paper: MENTAL ILLNESS: FROM STUMBLING BLOCK TO STEPPING STONE. Jeanette Sherington Diane Bowerman, John Dawson, Sheryl Goscombe, Gwyn Jones, Bruce Pidgeon, Cath Thom, Ray Whitehill The paper is developed by the Consumer Consultants as a group and will be presented by two of the Consumer Consultants. The paper presents an intimate view of the Consumer Consultant Project established in Hobart Tasmania as an example of one of the models of Consumer Consultants work. **The dream:** Changing the perception of mental illness as a stumbling block, preventing mental health consumers from pursuing their life plans. **The reality:** The project acknowledges and values the experience and knowledge consumers have gained about the mental health system as being of assistance to others. Consumer Consultants have an important role in the improvement of the care and treatment of mental health consumers. Individuals gained a stepping stone in their particular journey to pursue their own life plans. The Presentation Presentation covers a brief history of the reality of establishing the project, some of the difficulties encountered and how a review and its recommendations helped in moving on. We explain the process of the development of the short training course and ongoing professional development of consultants and its importance in providing a stepping stone to further opportunities. The research survey implications for the future development of the project and the development of a career path for consumer consultants are outlined in this presentation

212 Paper: CONSUMER RESEARCH -THE REALITY Jeanette Sherrington, Gwyn Jones The paper presents the findings of a research survey of Consumer Consultant /Peer Support/ Consumer Specialist Participation type projects in Australia. The survey was conducted to bring together a body of information on these projects as a valuable guide to the opportunities for our own Consumer Consultant project. These findings will interest the network of Consumer Consultant Projects and potential projects. The research explores the diversity of the area of Consumer Consultant type projects. It maps the geographic location and coverage of the projects. It identifies the range of activities that are being

undertaken by the projects. It ascertains the variety of sites where the Consumer Consultant work takes place eg. hospital inpatient setting, community, Govt department committees. It outlines the extent of training available to mental health consumers interested in working as Consumer Consultants. It delineates the field of requirements within position descriptions. It considers the variety of structural arrangements of the projects. It documents the funded or voluntary nature of the projects. We will discuss the implications of the research for the development of Consumer Consultant work and the opportunities for mental health consumer participation in policy development, service planning, service delivery and service standards as required under National Mental Health Standards

213 Paper: INTERVENTION FOR CANNABIS USE AND SCHIZOPHRENIA IN THE COMMUNITY. Rolfe TJ, Williams S, Kulkarni J.: Clients of the public mental health services most commonly suffer from Schizophrenia. Cannabis is the most commonly used illicit drug in this population. A number of studies have demonstrated a relationship between the two problems, causality is not simple and a complex interaction is most likely. There is a high likelihood that neither the so-called "self-medication" hypothesis, nor the straightforward causation or worsening of symptoms of psychosis, can explain the association alone. It is distinctly possible that at least both of these hypotheses are true, and may be true for the same individual at different stages of their illness. This project was designed to provide pilot data describing the natural course and treated course of Schizophrenia when clients used cannabis. The study aims to recruit 20 people into the intervention and compare outcome over a six month period with 20 people in a comparison group. All participants are assessed initially using a structured diagnostic interview and are rated monthly using standardised rating scales including the Positive and Negative Symptom Assessment Scale (PANSS), Montgomery-Asberg Depression Rating Scale (MADRS), Cannabis rating scales and Quality of Life Scale Intervention is conducted by a Psychiatrist who utilises a "biopsychosocial" model to guide treatment. Thus, medication issues are addressed initially with the aim of optimal symptom control. Diagnosis of comorbid anxiety and affective disorders is important during this phase, as adjunctive treatment is sometimes necessary. During this phase open communication regarding cannabis use is encouraged. A harm-minimisation philosophy guides psychological intervention. Clients are encouraged to discuss the potential beneficial and negative effects of cannabis use and weigh their decision to continue use. The social determinants of use are addressed by attention to living conditions, peer/family relationships, educational, vocational and leisure activities .Progress results will be presented for at least five clients involved in the intervention group. Baseline characteristics will be compared with an unmatched comparison group of clients who declined to be involved in the study. Female cannabis users, although less frequent, are more likely to want to stop using. Clients who accept the intervention use relatively greater amounts of cannabis and report greater paranoia, depression and suicidally. Those who decline help report that cannabis makes them feel good, increases their energy and concentration. The implications of these preliminary results for intervention will be discussed

214 Poster: ASSESSMENT OF CANNABIS USE. Rolfe TJ, Williams S, Kulkarni J. Co-morbid diagnosis of cannabis use and psychosis is common. While valid assessment instruments exist for diagnosis and symptom rating of psychotic conditions, no suitable instruments exist for the assessment and measurement of cannabis use in the presence of psychotic conditions. Research has been hampered by the lack of such assessment tools. Two questionnaires have been developed to assess cannabis use in a routine and structured manner. The first questionnaire measures quantity, frequency, method and type of use, as well as recording some symptoms of possible dependence. The second questionnaire looks at circumstances of use and reasons for use, with the aim of tailoring potential interventions to individual persons needs. Each questionnaire fits on one page and takes less than five minutes to complete. The usefulness of the questionnaires is enhanced when they are administered during an interview. This poster describes the questionnaires and summarises results obtained by their use in a number of studies at the Dandenong Psychiatry Research Centre. The results are based on a sample of 40 clients. The majority of users are young males, smoking the most potent forms of cannabis, over a long period of time. Furthermore, it was found that clients readily complete ratings of good and bad effects of cannabis use. The most prominent among perceived good effects is the relief of boredom, assistance with sleep and 'good' emotional state induced by the cannabis. Alterations in side effects of medication are rarely reported, modification of hallucinations and paranoia is also uncommon. In summary, both questionnaires appear, even at this early stage, to be very useful clinical tools. Conference delegates will be free to obtain copies of the questionnaires for clinical and research use. This initiative is designed to encourage greater collaboration and communication amongst researchers in this field

215 Poster: MINIMISATION OF CANNABIS USE IN THE INPATIENT SETTING. Rolfe TJ, Williams S, Eadie L, Kulkarni J. : Anecdotal evidence suggests that cannabis use is common in psychiatric inpatient units. To date there has been no systematic survey of such use. Given that cannabis use is felt to be a precipitant for admission in some people, it is of concern that inpatients continue to use cannabis. This can lead to prolonged admission and failure to respond to the usual treatment regime. An attempt to minimise cannabis use while in hospital is founded on a high index of suspicion that such use is present. The inpatient group program at Dandenong Hospital has included a group intervention to address the problem. Inpatients are referred by the ward team if they consent, have used cannabis in the past and are thought to be at risk of future use. Participants complete cannabis use questionnaires at entry and weekly self-assessment thereafter. Urine drug screens are collected weekly. Weekly rating by the primary nurse consists of the Clinical Global Impression (CGI) Scale and a cannabis use rating scale. Group attendees participate in a semi-structured group of one hour duration, once per week, led by a Psychiatrist and an Occupational Therapist. The group is open in format and addresses ongoing cannabis use using a harm-minimisation approach. Attendance at the group has ranged from 2-6 inpatients per week. Two thirds of attndees have been male. The most common diagnosis are schizophrenia and schizophreniform psychosis. Mean duration of admission is 4 weeks. Both self-report and nurse-report are accurate methods of assessing cannabis use by comparison with urine drug screens Several principles have emerged that guide the activity of the group, they include, focus on engagement, harm-minimisation, emphasis of choice and avoiding giving advice and information. Challenges remain and include a low referral rate from inpatient nursing staff and a high degree of therapeutic pessimism

216 Paper: A FAMILY INTERVENTION FOR CANNABIS USE AND PSYCHOSIS R. Sheils, T. Rolfe, J. Kulkarni, S. Williams ACT: Co-morbid substance abuse and schizophrenia is problematic from a clinical, economic and health care systems perspective. Existing treatment strategies are inadequate due to the lack of systematic research into the unique problems facing this dually diagnosed population. As a result, there is a significant burden on the existing mental health delivery system. Additionally, there is a huge burden on families who are left with the onerous task of caring for dually diagnosed individuals. This highlights the need to incorporate families into the treatment of co-morbid substance abuse and schizophrenia. This paper describes the rationale for a group intervention for carers of cannabis using clients who have Schizophrenia. It will commence with a review of the literature on family interventions for both substance abuse and schizophrenia synthesising these two areas in order to outline approaches to family therapy that could be used with this dually diagnosed population. The intervention will be a multi-family, closed-group intervention of fixed duration. Components of the intervention will include psycho-education, harm-minimisation, communication training, problem solving and crisis intervention. Rigorous methods of evaluation will be used to assess the intervention including standardised assessment tools focusing on client, carer and system outcomes. The purpose of this presentation is to encourage consumer and carer discussion of the issues relevant to a carer intervention for cannabis use and Schizophrenia that can then be used to feed back into the design of the intervention

217 Paper: ADJUNCTIVE ESTROGEN IN THE TREATMENT OF PSYCHOTIC SYMPTOMS IN WOMEN- PHASE II J. Kulkarni, A. Riedel, A. deCastella, P. Fitzgerald, T. Rolfe, J. Taffe & H. Burger Estrogen has been postulated to provide protection against severe psychosis in women. Women generally respond better to treatment with neuroleptic drugs than men. However, post-menopausal women require higher doses of neuroleptic drugs for effective symptom treatment compared with pre-menopausal women. Women also have a higher risk of developing schizophrenia or relapsing during the post-partum period, after menopause and at low estrogen phases of the menstrual cycle. There are clinical case reports of women whose schizophrenia symptomatology was exacerbated at low estrogen phases of the menstrual cycle. A recent-study investigating the relationship between schizophrenia psychopathology and low estrogen phases of the menstrual cycle showed that symptoms improved when natural estradiol levels increased. Following these clinical clues that estrogen may be a useful treatment in psychosis, we conducted a clinical adjunctive estrogen treatment trial in pre-menopausal women suffering from schizophrenia. The women who received 0.02 mg oral estradiol as an adjunct to antipsychotic drug treatment made a significantly more rapid recovery from acute psychotic symptoms, compared to a similar group of women who received antipsychotic drug treatment alone Subsequently we have conducted a double blind placebo controlled study in a total of 31 women with schizophrenia, using 50 micrograms of transdermal estrogen as an adjunct to antipsychotic drug treatment. 18 women received adjunctive estrogen and 13 women received a placebo patch. Our results show that women receiving estrogen recovered more rapidly than those receiving neuroleptics alone with respect to the BPRS, total PANSS, and its

corresponding Negative and General Symptom subscales, especially in the first 4 - 7 days. No significant differences were found in positive symptoms or in hormone levels at any time point, which suggests that the dosage of estrogen is insufficient. Following from this we are currently conducting a 100 (g estrogen study, which show promising results

218 Paper: A PRELIMINARY ANALYSIS OF THE SCHIZOPHRENIA CARE AND ASSESSMENT PROGRAM IN AUSTRALIA Corteling, N, Adams, A, de Castella, R., Montgomery, W., Hopkins, S., Davey, P., Hirstova, L., Rolfe, T., & Kulkarni, J. The Schizophrenia Care and Assessment Project (SCAP) is a multicentre study that aims to measure real world data on the care of three hundred clients with Schizophrenia. Each client is followed over a three-year period with six monthly assessments. The project uses the SCAP instrument, which is a 100-question assessment tool, designed to be a brief reliable method for collecting outcome data on a sample of clients with Schizophrenia and related disorders. The aim of SCAP is to improve the quality of mental health care for people with Schizophrenia by disseminating the outcome information gathered to service providers. It also aims to document and measure the treatments used, as well as their outcomes and the costs for clients with Schizophrenia. In addition to the SCAP questionnaire, a battery of assessment tools measuring psychopathology, movement disorders, depression, quality of life and a Global Assessment of Functioning scale are administered. Baseline results are presented for the first 100 clients enrolled. Results show that more than twice as many men than women have been consented into the study. Women were found to have longer periods of hospitalisation but lower levels of negative symptoms when compared to men. Other differences in the key measures of quality of life, severity and duration of illness, as well as the incidence of use and tolerability of older versus newer types of anti-psychotics will be presented and discussed

219 Poster: NEUROCOGNITIVE FUNCTIONING AND QUALITY OF LIFE IN PEOPLE WITH SCHIZOPHRENIA ENROLLED IN THE SCHIZOPHRENIA CARE AND ASSESSMENT PROGRAM (SCAP) C.Williams, W.Montgomery, A.Thomas, S.Hopkins, P.Davies, T.Rolfe, P.Fitzgerald, A.deCastella, A.Adams, N.Corteling, J.Kulkarni This poster will provide a comprehensive literature review and detailed description of the aims and methodology of the current study. Background & Objectives: Many studies have supported the notion that people with schizophrenia perform poorly across a variety of neurocognitive tests with the most profound neurocognitive deficits in attention, memory and executive function (Tollefson, 1996). In recent years there has been increasing interest on the quality of life (QOL) of patients with schizophrenia. As neurocognitive deficits are often regarded as a debilitating and devastating aspect of schizophrenia, it would be reasonable to suggest that cognitive deficits impact on the QOL of a person with schizophrenia (Heslegrave, Awad and Voruganti, 1997). There is a paucity of research into the relationship between neurocognitive deficits and QOL in schizophrenia. Therefore, the objectives of the current study are to:1. Test the hypothesis that neurocognitive deficits in schizophrenia impact negatively on the QOL of people with schizophrenia; 2. Test the hypothesis that neurocognitive deficits act as mediators of change in QOL; and 3. Examine whether clinical, demographic or external factors, such as type and/or degree of symptomatology, and gender, affect neurocognitive performance and QOL. This project is part of a bigger project namely the Schizophrenia Care and Assessment Program (SCAP). The SCAP aims to improve the quality of mental health care for people with schizophrenia by observing patients with the disorder worldwide over a three year period. Methodology: 100 to 150 participants from the Australian site of the SCAP study, with a diagnosis of schizophrenia or schizophreniform disorder will undergo testing at baseline and one year later. At each testing session participants will be administered an extensive battery of clinical and neurocognitive test instruments. The current study will cross correlate neurocognitive functioning with the quality of life and clinical rating scales

220 Paper: THE EPIDEMIOLOGY OF FIRST ONSET PSYCHOSIS: A PRELIMINARY GENDER ANALYSIS OF A TWO YEAR FOLLOW-UP PERIOD.Filia, S., Riches, P.,Arnott, A., Hardiker, T., Rolfe, T., Fitzgerald, P., & Kulkarni, J. Prior studies have clearly established gender differences in schizophrenia. The age of onset of schizophrenia in women is now well recognised as being 5-10 years later than in men. Gender differences in the course of treatment and outcome of schizophrenia have also been well-documented. Few studies have examined gender differences in forms of psychosis apart from schizophrenia. There has also been a lack of research exploring gender differences in first onset psychosis. This paper explores gender differences in first onset psychosis, based on data collected from an ongoing prospective, longitudinal study of all clients presenting for treatment for first onset psychosis to our service. Data has been collected on 181 first onset clients, who have been followed for a period of up to two years. The present study found gender differences in first onset psychosis consistent with prior findings. The age

of onset of psychosis in females was approximately 5 years later than in males. There were no gender differences in duration of untreated illness. A greater number of males were diagnosed with schizophreniform disorder and drug-induced psychosis. Significant gender differences in treatment location were found, indicating that males were more likely to require treatment in the inpatient facility at some point of the episode. These results will be discussed in the context of previous findings

221 Paper: MEDIA MADNESS Oscar Ferreiro Aims: To analyse the ways in which the mass media constructs the idea of 'mental illness'. To propose strategies for challenging these ideas through the use of new communication technologies. Educational objectives: Participants will learn about how the mass media promotes negative and simplistic ideas of what constitutes 'mental illness'. They will also be made aware of how the new digital technologies, such as the Internet, offer opportunities to tell other stories and create new online communities. The mass media objectifies and institutionalises the concept of mental illness in our society. The unified negative portrayal of 'mental illness' leads to an oversimplified image of suffering and crisis, and perpetuates the myth of madness as threat. But does 'mental illness' exist outside its mass media representation, or is it a construct not locatable beyond it? If 'mental illness' is a mythologised construct, what sort of strategies are available to combat its promulgation? This paper will illustrate the ways in which the mass media uses images and text to construct and perpetuate specific ideas of 'mental illness', citing actual examples and comparing and contrasting them with examples of information found on the Internet. It will also situate contemporary constructions of mental illness within a diachronic analysis of ideas of mental illness and madness. The paper will explore the existence of voices whose stories are not being heard in the mass media, and the emerging digital technologies which enable the creation of new spaces for these voices to speak. Do these voices tend to confirm the mental illness construct, or do they challenge it? The paper argues that the representation of 'mental illness' in the mass media inculcates a narrow view of 'mental illness' which isn't useful in assisting the treatment of suffering people, nor in reconciling sufferers with their community. New digital communication networks provide an opportunity to tell different stories, to challenge prevailing ideas about what constitutes 'mental illness' and to promote positive attitudes about mental health

222 Paper: AN EVALUATION OF A FEEDBACK LOOP IN RESEARCH DESIGN: CRITICAL ISSUES AS IDENTIFIED BY CONSUMERS AND STAFF Ross Findlay, Merinda Epstein, Ellie Fossey, Gillian Plant, Carol Harvey It is necessary to better understand the strengths and difficulties in daily functioning of people living with schizophrenia. Therefore, the everyday task performance, social behaviour and thinking of a group of forty such individuals have been assessed, within a quantitative study. Feedback to each consumer participant, together with their key-worker, was incorporated in the study design. Feedback concerned the ability of each consumer to carry out problem solving and other areas of complex thinking and to perform their usual daily living activities. There was a need to evaluate this feedback, since it is a relatively novel aspect of research design. This paper will present the findings. Two consumer researchers, who were not involved in the quantitative study, interviewed 18 consumers and 11 staff. A qualitative exploration of the experience of participating in the research and receiving feedback was conducted. Detailed notes were taken of people's responses to a set of open-ended questions, and then analysed thematically. Overall, consumers and staff valued feedback from research and were generally positive about the process and content of the present study. This paper will focus on the findings to highlight what makes a good research project as identified by consumers and/or staff: research should benefit participants as well as researchers at both an individual and systemic level therapeutic and research goals should coincide consumers may need to discuss what they 'think they heard' with both their key-workers and researchers both positive and negative feedback must be sensitively presented by researchers (eg. a focus on strengths) and may even need to be counselled Furthermore we have found that: the process and method of interaction between researchers and participants is an undervalued yet critical aspect of research design

223 Paper: WHAT DOES A STRENGTHS BASED APPROACH OF NEUROPSYCHOLOGY CONTRIBUTE TO CLINICAL PRACTICE WITH PEOPLE LIVING WITH SCHIZOPHRENIA? Gillian Plant, Carol Harvey, Ellie Fossey, Paul Maruff, Chris Pantelis There is a growing body of literature examining the relationship between schizophrenia and cognitive deficits. As a group, people living with schizophrenia may experience impairments in any aspects of attention, memory and executive function. However, just as symptom atology differs between individuals, studies in the neuropsychology field are now recognising that not everyone suffering from schizophrenia experiences the same cognitive difficulties. Although this has been acknowledged in the research, cognitive rehabilitation programs continue to see individuals with schizophrenia as a group, focusing on deficits, and neglecting an

individuals' strengths. This paper will discuss preliminary results of a research study which involved 40 people living with schizophrenia and receiving treatment from two services: 24hr supported accommodation and mobile treatment and support teams. The aim of this project was to identify a person's strengths, as well as areas of difficulty, from a comprehensive evaluation of memory, attention, problem solving and other areas of complex thinking. This paper will describe: the variation between individuals with schizophrenia on tasks of cognition areas of strengths on tasks of cognition how strengths can be utilised to overcome or compensate for areas of difficulty Furthermore, we will give practical recommendations on how a focus on strengths can enhance service delivery in a clinical setting, based on: individualised assessment providing feedback contextualised to assist the person in his/her everyday life.

224 Paper: CO-MORBIDITY OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS PROJECT Margaret Tobin, Cynthia Stuhlmiller, Luxin Chen, Rosemary Roisin Smith Background Comorbidity of mental health and substance use disorders is acknowledged as a priority issue for service development and planning at State and Commonwealth levels. South Eastern Sydney Area Health Service has taken up the challenge of facilitating a collaborative service approach to the issue of Mental Health and Drug & Alcohol Services. Aim The aim of the project is to develop an integrated service model which encourages generic organizational change rather than promote a specialist program to improve the quality of service delivery to clients with comorbidity. Special emphasis was placed on achieving change through facilitating clinical discussion around issues pertinent to local service delivery and planning for clients with comorbidity. Method The method employed for this project was guided by a steering committee with representation from Mental Health & Drug & Alcohol Services across SESAHS. Using an Action Research Framework involving discussion with and feedback from clinicians, consumers and carers, the steering committee reached consensus on the following issues: Data collection processes Screening Level of service provision and processes of care Guidelines for joint case management Results SESAHS has developed a model of care which identifies appropriate levels of service delivery for clients requiring mental health and Drug & Alcohol services. The model initiates joint clinical case conferences and co-case management for clients who meet criteria of comorbidity. As clients progress through the levels of service, the quality of data collected on comorbidity increases and is fed into a continuous quality cycle which aims to improve service delivery and planning for this client group over the long term

225 Paper: TO ADMIT OR NOT ADMIT ACUTE PSYCHIATRIC PRESENTATIONS AN EVALUATION OF THE DECISION MAKING PROCESS Margaret Tobin, Ian Hickie, Lucy Chen, Pamela Hudson-Jessop Background: There is a generalized excessive demand pressure on acute beds which requires a management response. However, acute beds are only one component of a comprehensive system of care. A variety of service organization and psychosocial factors contribute to the demand for inpatient care. Hypothesis: Improved understanding of the decision to admit/not admit will allow better management decision making. The clinician's decision to admit/not admit is influenced by subjective factors such as the perception of bed availability and the influence of both the consumers' and carers' opinions. Aim: To develop a methodology for better understanding of clinician decision making by trialling a tool which assists our understanding of this process and validating the tool across systems of care. Methodology: The numbers of presentations to points of access of one urban and two rural area mental health services were identified for one week periods throughout the year. This identified two cohorts: those admitted and those not admitted. Factors associated with the decision to admit/not admit were identified by file audit and clinician interview, both of which were based upon a modified version of the Level of Care Utilisation System (LOCUS). In addition to clinical factors, the influence of service factors (e.g. bed availability) and support networks (e.g. carers) were identified. Results: Approximately 100 cases were identified across both the rural and urban sites. It was demonstrated that both service factors and the availability of community support networks influenced the clinician's decision to admit or not admit. Conclusions: It is possible to increase the objectivity of understanding of a variety of psychosocial and service organization factors that contribute to the decision to admit/not admit. The LOCUS tool was able to assist our understanding of the decision making process. It is predicted that the tool may be useful in increasing the objectivity of clinician decision making and hence allow comparisons of decisions by different groups. This comparison will have implications for the management of acute psychiatric bed demand.

226 Paper: EVALUATION OF CONSUMER PARTICIPATION PROJECT: FOSTERING A PARTNERSHIP Margaret Tobin, Cynthia Stuhlmiller, Lucy Chen, Stella Chan Consumer participation is a new buzzword in human services. In mental health, it has become increasingly common to hear governments, community agencies and planning groups talking about involving the consumer,

getting consumer input, or consulting with users of services. However, consumer participation continues to pose challenges. The aim of the present project is to evaluate the extent and nature of consumer participation within the South Eastern Sydney Area Health Service. A steering committee was set up to oversee the project and included consumer representatives. This project is one of the first projects in the Area with consumers and staff working in partnership to evaluate an aspect of the service. Initially service providers did not know how to effectively work in partnership with consumers. In order to learn how to manage a partnership, service providers were challenged to ensure consumers had a comfortable environment to freely exchange ideas and voice concerns. The project employed a qualitative research method and relied on consumers to obtain the information. Interviews with consumers were conducted to assess their understanding of and involvement in the three levels of consumer participation. The three levels of consumer participation being discussed included participation in treatment and recovery, participation in service delivery/policy, and participation in consumer lead activities. Consumer interviewers were recruited and trained for the project. Socio-demographic data was collected to examine whether there are any differences between consumers who agreed to participate in the project to those who did not. Data on the results will be presented and discussed. This paper will be presented as one of a pair, the other presentation which will be presented after this presentation will be the "Evaluation of Consumer Participation Project: Nothing About Us Without Us" presentation

227 Paper: EVALUATION OF CONSUMER PARTICIPATION PROJECT: "NOTHING ABOUT US WITHOUT US" Sandy Watson I was approached, in my capacity, as Area Consumer Co-ordinator, to participate in the Steering Committee overseeing the evaluation of consumer participation within the South Eastern Sydney Area Health Service. I saw this as an important opportunity to engage in the research process from the very beginning, and influence the direction in which the evaluation was going to move. I will present a consumer perspective on the experience of participation on the Steering Committee. In my paper I will talk about:1. Steering Committee Issues, including: "Nothing About Us without Us" reflecting the importance of consumer participation throughout the entire process of evaluation. The process involved in recruiting consumers for the Steering Committee. The barriers in the Committee process, and how we overcame them The Committee dynamic - what it was like to participate. Mapping out fundamental Project issues together: definitions; scope; what is consumer participation; 3 levels of participation. Recognising that this process was new to most of the Committee members and wanting it to work for everybody involved.2. Research issues, including: The challenge for consumers in handling complex discussions over research methodologies, and unfamiliar concepts. Which consumers were we interviewing, where, and when, how? The implications in taking a new direction in adopting an 'empowerment research' methodology, and what the implications of this were likely to be. In deciding to recruit consumers as interviewers, there were issues to resolve about their recruitment; training and support needs. The evaluation questionnaire was consumer written - with the final revision being done by the Steering Committee.3. Recruitment issues, including: Preparation of the written material: advertisements; consent forms; explanations of the evaluation project; job application form. We worked hard to ensure that everything was written in a consumer friendly way. Consumers on the Steering Committee felt encouraged by the opportunity to participate, from the beginning, in the Evaluation of Consumer Participation Project. We developed in confidence as the meetings progressed, and felt comfortable about saying what we thought. There were inevitable tensions: things that were important to us didn't necessarily coincide with things that were important to the Mental Health Professionals on the committee. We were an integral part of the all of the decisions: the Professionals on the Committee were prepared to take the leap into uncharted territory. If partnership is about open communication, we achieved that. If Consumer Participation is about consumers taking on new challenges in life, then some of the consumers on the Steering Committee have done just that, gone on to full-time study; volunteering for St. John Ambulance work at the Pan-American Games in Canada. If empowerment is about everybody in the partnership relationship benefiting, then it is my hope that all members of the Steering Committee have been empowered, in some important way. This paper will be presented as one of a pair, the other presentation which will be presented before this presentation will be the "Evaluation of Consumer Participation Project: Fostering a Partnership" presentation.

228 Paper: DEVELOPMENT AND IMPLEMENTATION OF MENTAL HEALTH TRIAGE GUIDELINES FOR EMERGENCY DEPARTMENTS Margaret Tobin, Elizabeth Scott, Luxin Chen, Nicola Mellick General hospital Emergency Departments (ED) are an important point of contact for people who need urgent service from mental health professionals. In the past, inappropriate management of mental health presentations has led to many undesirable outcomes. The National Mental Health Policy has

placed pressure on EDs to improve the management of mental health presentations to EDs. With inadequate guidelines for ED staff to triage mental health patients and inadequate knowledge and skills in dealing with people with mental health problems, the tension between Mental Health Services and EDs has increased. The South Eastern Sydney Area Health Service (SESAHS), via its Area Mental Health Program set up a project which aimed to: (1) improve the quality of clinical management of Mental Health emergency presentations to general hospital EDs, and (2) improve the relationship between the Mental Health and Emergency Department staff. A Steering Committee was established to oversee this project. It comprised Mental Health Service Managers, Psychiatrists, ED Physicians, ED Clinical Nurse Consultants and Specialists, and Mental Health CNC. The project consisted of a number of stages: (1) development of the Mental Health Triage Guidelines, (2) the collaborative development of educational materials for ED staff, (3) training conducted at each site by ED and Mental Health staff, and (4) piloting and evaluation of the guidelines conducted.Results:1. 500 emergency presentations were recruited in pilot study. 2. Validity and reliability were tested by the indicators e.g. adverse events, repeat presentations, and waiting time.3. Education package to help triage nurse to use Mental Health Triage Guideline has been developed and trialled. 4. The evaluation was completed with emphases in: - Usefulness of guidelines to staff- Acceptability according to Emergency Department/Mental Health- Changes to Clinical Practice which result- Adverse Events monitoring- Monitoring sensitivity of guidelines. Discussion item: Paper will discuss the process of guidelines development, training implementation, and evaluation from the perspectives of staff of both departments and clients who have potentially benefited.

229 Paper: "WE WANT TO THRIVE NOT JUST SURVIVE" Linette Bone **I am a Performance Poet with twenty five years of experience as a mental health consumer, twenty years experience as a published and performance Poet, twenty years experience as a teacher, welfare worker and mental health consumer advocate. In 1998 I was funded by the ACT Government for a Professional Development Grant to present a poetry performance at the National Mental Health Consumers Conference in Adelaide. I am currently working part time as the Administrative Support Worker with the ACT Mental Health Consumer group .I believe as consumers, whether 'professional or normal', that we firstly have to have dreams. It is too easy to give up a belief in our capacity to dream. Only when we dream can we join to share and inspire – not just with other consumers but with all stakeholders. I offer to present at the 1999 THEMHS Conference "Whose Dreams? Whose Realities?" a twenty minute poetry performance united by my subtheme "We Want to Thrive Not Just Survive". The performance will consist of an articulate professional reading of the seven poems (a mixture of published and unpublished work as I want to give a taste of my inspiration from the 2nd National Mental Health Strategy):Hospitals are not necessarily places of Healing I Remember You may think you know me The Consumer Blues (hopefully to be accompanied on guitar)Survive to Thrive A Consumer's letter to Father Christmas (or) Millenia Milestones Sanity Each poem will be personalised and made relevant to the conference by a "planned spontaneous patter" which will interweave with the subtheme. Your conference title inspired me to write The Consumer Blues as a response to the challenge to 'paint'/share consumer reality honestly and usefully Whilst scheduling of poetry performance is entirely the committee's decision, I would like to add that my poetry performances are excellent as evening caberet/after dinner presentations. It is my task as a professional performance poet to read the mood of the audience.**

230 Paper: **SUPERVISION AND TRAINING OF FOREIGN GRADUATED PSYCHIATRISTS IN RURAL VICTORIA VIA VIDEOCONFERENCING: A PILOT PROJECT David Barton, Ken Burnett, D Chinnasamy** The shortage of psychiatrists in rural and regional Australia necessitates public sector hospitals employing foreign graduated psychiatrists. The under-supply of psychiatrists is unlikely to resolve in the near future, and so foreign graduated psychiatrists will continue to be employed by country hospitals. The Royal Australian and New Zealand College of Psychiatrists is encouraging foreign graduated psychiatrists to obtain the College Fellowship. This process aims to ensure adequate standards of clinical care by all psychiatrists practicing in Australia. The major difficulty for these psychiatrists is access to training due to the tyranny of distance. In order to address this the North West Health Mental Health Program has developed with Warrnambool & District Base Hospital a pilot project to provide exam preparation and supervision for their psychiatrists via videoconferencing. This project was implemented in January 1999 and involves 2-3 hours of supervision per week. Warrnambool & District Base Hospital has a responsibility to organise Medical Supervision for their foreign graduated psychiatrists. They also have a

policy of providing ongoing supervision for all staff, no matter how senior. They regard this as an important quality assurance issue, which has been facilitated via this videoconference link with the Royal Melbourne Hospital, Mental Health Program. This presentation will cover the following: How to set up a videoconferencing supervision program. Accreditation of this program with the relevant authorities, especially the Medical Board. How to develop a business plan for such a service. A description of the program and results of our first six months. Legal and ethical issues. Costs savings that have ensued from this program. Suggestions for future directions. Conclusions: The supervision of foreign graduated psychiatrists via videoconferencing is an effective means of overcoming the isolation of rural psychiatrists. It allows linkages to specialty services, which improves the quality of patient care. For the health provider there are significant cost benefits. Strategies for expansion of this pilot project to provide a service to a larger number of psychiatrists will be discussed

231 Symposium: SERVICE BACKGROUND Jamie Terzi Stephen Emmett Western Respite Services is a "Planned Respite Service" The service is a relatively new agency which has operated in the Western metropolitan region of Melbourne for almost two years. Planned Respite is a new service developed at the Richmond Fellowship of Victoria. This service is for people with a psychiatric disability and their carers. It is a brokerage service. This means that we will purchase or provide the respite service which is requested or identified by the person with a psychiatric disability and carer/co-resident as most meeting their need for respite. Care and support options have been developed and have an emphasis on the processes of psychosocial rehabilitation. The work of the service has focused on providing in home support, individual and group outings and assistance in accessing community activities. Respite workers have been employed in the provision of individual and group holidays. For Western Respite the services delivered so far have come under five headings: Supported group holidays Supported individual holidays Flexible in home support / One-on-one activities This type of respite usually involves building a short-term relationship between a respite worker and client for more intensive involvement towards building a person's links and confidence. An example of this type of respite include providing in home support for two young women for two months. This allowed their parents to travel to London to deal with urgent family issues. To date, ten in-home support options have been provided. Group outings and recreation activities Short term alternative accommodation and support / emergency respiteThis category refers to a small number of emergency accommodation placements, which is provided when usual care is unavailable through illness or mishap.The age range for participants of the service includes Child and Adolescent, Adult and Aged persons. The service is offered to people with a psychiatric disability and their carers, who live in the western metropolitan region of Melbourne. Essentially the program aims to provide a *temporary* break from the usual care and support arrangements for a person with a psychiatric disability. Respite services support, maintain and enhance the existing supportive relationships for a person with a psychiatric disability. Respite is a *short term* service by its very nature but can be regular or once off. Planning for respite is an important part of the ongoing recovery and support for people with a psychiatric disability and those who provide care for them. Services are planned in collaboration with other services: e.g. clinical services, community support services and can be once off or regular, day, evening or weekends.

232 Paper: THE IMPACT OF HOUSING STABILITY ON MENTAL HEALTH OUTCOME Gordon Lambert, Frank Deane Research on the impact of homelessness on people suffering from a mental illness suggests that homelessness represents only the extreme end of a continuum of housing instability. Many people who cannot be classified as homeless "live in stressful, substandard and transient circumstance that can be considered unstable" (Drake and Wallach et al., 1991). The impact of housing instability has major implications for mental health services. For example, a study of mentally ill clients living in an urban centre indicated that those with unstable housing arrangements were twice as likely to be rehospitalised as those with stable housing (Drake et al. 1989).Unfortunately, studies of housing instability and homelessness have been undertaken almost exclusively in urban areas. There has been a paucity of research in rural areas about housing problems for people with mental illness. This paper:1. Reviews difficulty in comparing prior research due to wide variations in the definition of "instability".2. Describes levels of housing instability in a sample of 101 people who were using mental health services in a rural area of NSW. 3. Assesses the relationship between housing satisfaction, choice of housing and instability The implications of these findings for housing people with a mental illness in rural areas are discussed

233 CHAMPS CAMPS FOR CHILDREN AND YOUNG PEOPLE WHO HAVE A PARENT WITH A MENTAL ILLNESS Rose Cuff, Mark Mignanelli, Melanie Renwick, Matthew O'Brien, Sue Wragg, Garrett O'Dowd The questions and revelations come thick and fast, so that they compete for 'air time' to pose their question or describe a particularly harrowing event. Watching hands being raised in the

air, frantically trying to get answers they haven't had before, saying things never before said. Looking around and realising they are not aliens from another planet just because they have a Mum who is different. Seeing the seasoned players offer advice, comfort. Watching in awe as the 13 year-old tough boy gently wove beads in to the hair of a quiet nine year old, quietly talking. Makes the exhaustion by Sunday night worthwhile. (camp leader)The C.H.A.M.P. Project (**Ch**ildren **A**nd **M**entally Ill **P**arents) was funded by the Commonwealth Government, Department of Family Services, from 1995 – 1997. The project was based at the Mental Health Research Institute (MHRI) Victoria, and the peer support programs which eventuated were a collaborative venture between Abercare Family Services and MHRI. The project aimed to promote an awareness of the issues for children who have a parent with a mental illness and to develop services for children and their familiesThe CHAMPS programs and camps were premised on the belief that children benefit from an understanding of what is happening to their parent; that this information may be most effective if given in an environment of peer support, trust and plenty of fun; that parents, with or without a mental illness, want the best for their children and benefit from opportunities to provide this; and that these children remain largely 'hidden'. The CHAMPS programs have involved over 50 children aged 9 – 14 and their families. This workshop will give two long standing CHAMPS participants, both aged 15, the opportunity to describe their experience of parental mental illness and the things they have found helpful in their respective journeys, including the CHAMPS camps. A description of how the camps have evolved will also be given. The workshop will be largely interactive. We hope that workshop participants will be so inspired by these young people that they will go home and plan more CHAMPS-like activities

234 Paper: "SUCCESSFUL COMMUNITY PARTNERSHIPS -MEETING THE NEEDS OF PEOPLE LIVING IN BOARDING HOUSES." Julie Millard Since the 1970's mental health services in NSW have placed little emphasis on community development activities to enhance service delivery. The Joint Enterprise Service Initiative (JESI) Boarding House Project is an innovative community development approach as a component of a community mental health team. The JESI Project develops partnerships between consumers, advocacy services, government, non government agencies and interested groups. These partnerships form effective community structures and develop specific strategies required to meet the identified unmet needs of people with disabilities living in licensed boarding houses. The approach has a multi-faceted focus involving local communities, area, regional and state based services. A number of community development strategies have been successfully implemented in the Inner West of Sydney. These have resulted in increased individual and community awareness, participation of residents and allocation of resources to specific programs. Community groups working together with agencies and residents of boarding houses have created a community garden, ran consumer forums, art workshops and exhibitions, literacy programs, theatrical productions and held an Expo of service providers. The paper will discuss the lessons learnt from the project which have an application to the community health movement. It is believed that a community development approach increases the effectiveness of a service and assists consumers to become part of mainstream services. This paper will also discuss the strategies utilised by the JESI Project and present slides of specific resident programs. Please note: A 7 minute video of the Garden Club project is available for viewing.

235 Paper: DEVELOPING PARTNERSHIPS BETWEEN SCHOOLS AND MENTAL HEALTH SERVICES Glenn Rutter Schools can play a critical role when a student develops a mental illness. Teachers and/or school welfare personnel are often the first to identify that a student is experiencing a mental illness and are often the agent of referral to mental health services. Schools also arguably have a vital role to play in the recovery process. However, when a student becomes a consumer of a mental health service, such as a CAMHS, the school's role in the life of the student is often not recognised by the mental health system. For instance, teachers and school welfare staff report frustration at not being consulted by mental health services even though they may have useful insights into the needs of the student concerned. This paper argues that when a mental health service is involved in the care of a school student there is a need for an effective partnership to be developed between the mental health service and the school. Such a partnership can assist both organisations in ensuring that the student receives appropriate care whilst respecting the different role responsibilities and legal contexts of the two organisations. This paper aims to: (1) delineate some of the issues that can arise when a school student is also a consumer of a mental health service, such as those issues arising from concerns about confidentiality, conflict about role responsibility or differences in organisational culture; (2) highlight those features of the education system and the mental health system that may hinder effective partnerships between these systems; and (3) describe a model of partnership that ensures that the student who is also a consumer of a mental health service receives appropriate care from both systems.

236 Paper: I OWN MY HISTORY: A CHALLENGE TO THE INSTITUTIONAL RETENTION OF CONSUMER RECORDS. Jim Burdett Aims:1. To argue that the information contained in consumer notes is rightfully the property of that consumer. 2. To suggest ways in which this ethical imperative can be honored. Content: Ownership of notes is a similar issue to that of informed consent. Informed consent recognises the right of the consumer to their "self". Clients' records can be seen as an expression of this self. Furthermore, as the purpose of mental health care is the enhancement of autonomy then ownership of the notes by the consumer enhances that autonomy. The commonly stated justification for an institution to retain the records are:(1) convenience for the institution. (2) paternalism i.e. "trust me"(3) protecting the clinician against charges of malpractice. Objection (1) is trivial and can be satisfied with a range of procedures consistent with client ownership of the records such as: The records being held by the client. The records being held, subject to the client's consent, by the institution for the duration of the particular course of care. If the client is deemed incompetent the records could be held by the next of kin or any other person nominated by the client such as a solicitor. Objection (2) has some justification under the Hippocratic Oath. Information about a consumer's conditions can be upsetting to them thereby violating the injunction to do no harm. This argument is refuted by the well accepted requirement to seek informed consent; even when such action results in the consumer declining a life-saving procedure. Objection (3) is simply irrelevant as healthcare should always be in the best interest of the consumer rather than the best interest of the clinician.Conclusions:1. Client ownership of records has an ethical justification similar to that of informed consent.2. The practical difficulties of this ownership are surmountable

237 Paper: THE PHILOSOPHICAL COMMUNITY OF INQUIRY AS A MEANS OF REDUCING THE INCIDENCE OF YOUTH SUICIDE Jim Burdett Aim: To show how the skills of philosophical enquiry and the insights gained by the process can help to: a) Reduce the vulnerly of children and adolescents to the risk of suicide b) Create a mentally healthier society. The objective will be addressed with some statistical information and others' research data but principally through reasoned philosophical argument. I look at the issue of youth suicide principally in New Zealand but with some reference to the issue in Australia. I acknowledge the role that clinical depression plays in suicide and describe how personal and societal factors can precipitate depression and hence suicide risk. The societal factors include the current social, political and economic climate. I suggest a prophylactic remedy involving empowering young people by teaching the skills of philosophy; critical thinking, problem solving, exercising reasonableness, respecting persons, making ethical judgements, establishing self identity, and such. I argue that this process will mitigate both the societal and personal factors that predispose young people to suicide. Conclusion: Were the measures suggested implemented the effect on both education, the exercise of civic responsibilities and government policies would be profound

238 Paper: "NEW PIECES IN AN OLD PUZZLE:PARTNERSHIP CHALLENGES BETWEEN CONSUMERS AND MENTAL HEALTH SERVICES." Sandy Watson, Robyn Murray, The South Eastern Sydney Area Mental Health Service has developed, especially in the last 2 years, a range of Consumer Participation and Partnership mechanisms. Historically, Participation by consumers in service planning issues was based on ad-hoc arrangements at local sector levels. As a consequence of the new initiatives there is an increase in: shared decision making; co-facilitation by staff and consumers of Area-wide and sector level consultations; consumer input into policy development; dialogue processes between staff and consumers at all operational and administrative levels; and, overall, a greater focus on Consumer Participation strategies and issues. Partnership and Participation mechanisms are, however, not yet broadly based for either consumers or staff. There are fundamental questions and issues about the nature of the Partnership relationship that require attention. There are aspects of this relationship that remain confusing and sometimes puzzling. The challenges that the Service is facing in order to try and address the next stages of development are: there is no adequate model of Partnership that clearly explains some of the puzzling dilemmas that emerge; people usually understand why Partnerships should happen, but not necessarily how they should happen; there exists conflicting ideas about Partnership that create significant issues. Partnership challenges that require more thinking include: the paradoxical nature of Partnership (interdependence and autonomy need to co-exist in order for Partnership to work); misconceptions about consumer workers and consumer services; consumers and carers: the dynamics of difference role strain issues for staff, consumer workers and representatives confusion about the concepts of Power and Empowerment Once exploration of these issues is conducted, Partnership is more likely to develop within a clear framework of strategic planning and coherent goals. This development will be underpinned by dialogue that will continue to resolve conflicts and confused understandings about Partnership. The new pieces will then fit the old puzzle

239 Paper: IMPROVING OUTCOMES FOR HIGH RISK YOUNG PEOPLE - THE WORKING TOGETHER STRATEGY Bill MacDonald Being a young person today can be complex and difficult. For young people with a history of abuse or neglect along with mental health problems and problematic alcohol or drug use, even getting through each day can be a challenge. It is these young people, their families and other carers who are in greatest need of well coordinated support and care from health and welfare services. Historically, service responses to these clients have been uneven in quality. Services have not always worked well together in the client's best interest. As a result, clients may have had their needs met one at a time rather than in a planned or coordinated manner. To improve the standard of support and treatment, these young people and their families or other carers require agencies to work together in a trusting, transparent and integrated manner. In recognition of these difficulties, the Victorian Government has developed the *Working Together Strategy,* an initiative developed through partnerships between Mental Health, Protection and Care, Drug Treatment Services and Juvenile Justice The aim of the *Working Together Strategy* is to improve collaboration and coordination across services to ensure better outcomes for vulnerable children, young people and their families who come into contact with two or more of these service sectors. This paper will explore the evolution of the Strategy, describe its development and outline the planned initiatives aimed at improving ways of "working together".

240 Paper: ENHANCING PARTNERSHIPS - A SERVICE MONITORING FOCUS ON THE INTERFACE BETWEEN MENTAL HEALTH AND OTHER KEY SERVICE SYSTEMS Jenny Atta - Public mental health services in Victoria are being encouraged and challenged to work more effectively at the interface with other key service systems. Over the next two years new measures of service responsiveness are being introduced as part of the Victorian Mental Health Quality Incentive Strategy. A fundamental aim of the initiative is to improve service responsiveness to a targeted client group through bringing a focus to the key collaborative activities that underpin the intersectoral service delivery relationship. Adult, and child and adolescent mental health services are participating in an evaluation of service responsiveness to the needs of statutory clients (and their carers)of Juvenile Justice and Child Protection services. A similar service monitoring exercise is examining aged persons mental health services' responsiveness to the needs of consumers of community based and residential aged care services. In both instances the evaluation process has involved development of a tool with which mental health services rate their own performance and provide supporting documentation to be submitted to an independent expert panel. Outcomes are considered and analysed along with survey feedback collected from the 'other' service system. This paper will outline and discuss this service monitoring initiative. Particular emphasis will be given to exploring key concepts of service collaboration and coordination as well as identifying barriers to intersectoral service provision and opportunities to strengthen service performance in this area.

241 Workshop: NEW KIDS ON THE BLOCK - RESIDENTIAL REHABILITATION FOR YOUNG PEOPLE WITH MENTAL ILLNESS Lyn McKenzie In 1997/98, as part of the Victorian Government's response to its Suicide Prevention Taskforce recommendations, four new non-clinical residential rehabilitation services for young people with mental illness were funded. The following year, twelve more services were established. All sixteen were subject to a competitive tendering process. To date, successful tenderers have been non-government organisations with considerable experience in delivering psychiatric disability support. This workshop outlines factors essential for successful transitional residential services providing psychosocial rehabilitation programs for young people with mental illness between the ages of 16 to 24. These programs assist with the transition to adulthood by providing a communal living setting and encouraging activities appropriate for age and gender. Group peer support is utilised to assist young people to gain skills required for independent living and the development of effective social relationships. The workshop examines which type of housing is appropriate and the rationale for the use of congregate living arrangements for groups of 10 people, when the trend of service delivery in other human service programs is against such an arrangement. A number of organisations providing residential rehabilitation will outline their experience in establishing these services and the processes by which eligibility and priority for acceptance are determined. They will also discuss aspects of their programs which contribute to positive outcomes for clients, how they involve family and friends, any difficulties which have arisen and strategies to overcome them. The aim of the workshop will be to share background information and develop dialogue around effective support service responses to the needs of young adults with a mental illness.

242 Poster: TRANSFORMING VICTORIA'S MENTAL HEALTH SERVICES: SETTING POLICY IN CONCRETE Ralph Hampson The transformation of mental health services in Victoria has been dramatic. The shift of services from old Victorian institutions to community based services would not

have been possible without a massive injection of capital to renew and build new services for people living in the community. To achieve this goal the Mental Health Branch developed a range of generic briefs which provided the framework for the redevelopment of facilities. This poster display will provide a pictorial presentation of how policy has been set in concrete and the impact this has had on the lives of people with a mental illness, their families and carers.

243 Paper: Evaluation of Consumer Participation in Victoria's Public Mental Health Services Anne Jeffs, Gilbert Van Hoeydonck, This presentation will report on the findings from the recent review of Consumer Participation in Victoria's public mental health services. The objectives of the review were: To assess how effectively the policy of consumer participation has been implemented in Victoria's public mental health services with a view to improving consumer input into service planning, development, delivery and evaluation. To identify best practice in consumer participation locally, nationally and internationally. To provide recommendations about future policy development that will ensure meaningful consumer participation in mental health services in Victoria. The review ran from November 1998 through January 1999 and was informed by extensive consultation with stakeholders. The review found that significant progress has been made although there is considerable variation between Area Mental Health Services in both understanding of what consumer participation is and its purposes. This paper will detail the findings of the evaluation, probe their implications for stakeholders and explore opportunities to further partnerships with consumers

244 Workshop: KNOCK KNOCK - WHO'S THERE?A REPORT ON THE PSYCHIATRIC DISABILITY OUTREACH SUPPORT PROJECT Kate Paterson Since 1996, five workers in metropolitan Melbourne have been successfully providing an assertive outreach support service to people with a psychiatric disability living in low cost accommodation. This includes boarding houses, private hotels, supported residential services and caravan parks. This workshop will report on the progress of the project, highlighting those aspects of service delivery which are unique to working with people who are homeless and have a mental illness and which have relevance for other disability support services; as well as the innovative and specialist responses of the services involved. It will also explore the practical elements of service delivery, including characteristics of the client group, the structures and systems which need to be in place to make such a service work and the difficulties experienced. This workshop follows the 1998 THEMHS presentation by Kevin Carter on the development of the project, and co-presenters will be outreach workers from the Eastern Regional Mental Health Services Association, Inner South Community Health Centre and the Western Region Outreach Service

245 Paper: PUTTING A CAT AMONGST THE SURGEONS - ENHANCING AREA MENTAL HEALTH SERVICES (AMHS) RESPONSE TO PEOPLE AT RISK OF SUICIDE. Kevin Carter , Kate Millar In 1997/98, as part of the Victorian Government's response to its Suicide Prevention Taskforce recommendations, funding was made available for area mental health services (AMHS) to improve their response to people at risk of suicide. This included providing additional mental health services into emergency departments of public hospitals and ensuring the provision of after hours and outreach services for people at risk of suicide. This paper outlines the development of these services in the broader context of Victoria's suicide prevention strategy. It includes preparation of service specifications, statewide implementation and the development of statewide training. Issues which have arisen in a statewide review of service implementation will be discussed. The focus is on enhancement of the current crisis assessment and treatment (CAT) function of the AMHS. The additional funding enables 24 hour 7 day a week immediate assessment of all persons presenting at Emergency Departments (ED) who have intentionally self harmed, are suicidal or are identified as potentially at risk of suicide due to the presence of recognised risk factors. Importantly, this includes people who are intoxicated through alcohol or other drugs. The extra funding also means an improved direct response, on an extended hours basis, to similar referrals from the community. Clinical staff from the local CATS based in the ED also assist with the development of management and referral plans for these clients, providing short term management if necessary. The ongoing education and training of ED staff in identifying, assessing and managing persons who are suicidal or are experiencing a mental illness is a key part of their role

246 Paper: THE VICTORIAN CRIMES (MENTAL IMPAIRMENT AND UNFITNESS TO BE TRIED) ACT A NEW EMPHASIS FOR PATIENT, VICTIM AND FAMILY Ruth Vine After considerable debate, including a parliamentary committee inquiry, the Victorian Government introduced new legislation which commenced operation in April 1998. The *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* reformed the law for those previously found not guilty on the grounds of insanity and detained at the Governor's Pleasure. A major component of the new law is the process by which a patient

accesses the community via graduated leave progressing to variation of the order. The Act establishes the Forensic Leave Panel which hears applications for limited leave, and requires a hearing before the court of origin for the granting of extended leave or to vary the Order. The patient is involved in the application for leave and appears before the Panel resulting in a far more open process than was previously the case. Before a court hearing family members and victims of the offence must be notified, and are entitled to have input to the process. This paper examines the operation of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* from a clinical/patient perspective over the first twelve months. The process and outcome of the court hearings reviewing the status of patients previously detained is described. The effect of involving family and victim (often one and the same) and how this has been experienced by patients and staff is discussed.

248 Paper: ACHIEVING CHANGE IN VICTORIA'S MENTAL HEALTH SERVICES Joanna Birdseye, Victorian mental health services have undergone significant redevelopment over the past five years. This paper will track the key points of reform that have re-positioned the Victorian service system to one that has achieved widespread recognition as a leading model in the field of mental health services. The reform agenda was set out in *Victoria's Mental Health Services: The Framework for Service Delivery (1994).* Twenty-two mental health service areas spanning the whole State were identified and plans for the service elements; acute, non-acute, bed-based and ambulatory, were developed. This was underpinned by a purchasing framework which realigned the resources to meet the needs of consumers. Sixty per cent of Victoria's mental health expenditure is now in the community-based sector. This redistribution from institutional treatment to community-based care has allowed services to be more flexible and adaptable in meeting consumers needs. Specialist services have been established to meet the needs of consumers with specific needs. These include dual diagnosis, intensive youth support services, Koori mental health network, personality disorder service and dual disability services. Consumer participation has been essential to ensure accountability and best practice in mental health services. The case management system invites consumers and carers to participate in the development of a consumer's Individual Service Plan, ensuring active involvement in their own treatment and care. Consumers and carers are also actively involved in structural change within the mental health service system. Victoria already has a number of strategies in place to monitor the effectiveness of mental health services. These include clinical reviews undertaken by the Chief Psychiatrist, purchasing standards, key performance indicators and an increasing emphasis on outcome measurement across the service system. The Quality Incentive Strategy has been operating for 3 years and targets consumer and carer satisfaction and service responsiveness to particular target groups. The challenge is to integrate these monitoring activities to provide comprehensive feedback to services and foster an ethos of continuous improvement.

249 Workshop: MORE THAN A PASSIVE OBSERVER:INCLUDING CARERS IN MENTAL HEALTH SERVICES Cate Bourke, Deborah Leighton, Bronwyn Sutherland, Christine MacIntosh, Eoin Killackey, Samantha Watson .BACKGROUNDA carers perspective: When asked 'What would help you as a carer?' the response from many is summarised by the following. 'Just to take notice of what I say.'1 A workers perspective: 'The family unit, in my belief, is very strong and more powerful that the system that I'm coming from. So if I don't include the family...and work with them, then nothing will happen or things will go badly.'2Carers are fundamental in the support of a family member or friend who has a mental illness. 3 General feedback from carers and workers suggests that mental health services have experienced difficulty in providing a co-ordinated response to meeting carers' needs. Maroondah Hospital Area Mental Health Service (AMHS) has responded to this perceived difficulty by developing and implementing an integrated range of carer-centred programs in collaboration with carers. These programs provide opportunities for debriefing, peer support, networking, input to service development, and a range of ways of providing information and education, including families in group interaction .EDUCATIONAL OBJECTIVES At the end of this workshop it is expected that participants: Will become familiar with the principles underlying one services carer-centred programs. Will have a working understanding of the development, planning and implementation of the various programs. Will hear about difficulties encountered by this service and collaborative responses. Will hear a carer's perspective regarding the value of the approaches. Will hear the experiences of a carer employed to offer peer support in an adult inpatient unit setting. Will have opportunities to generate carer initiatives suited to their own AMHS, including discussion of likely challenges faced in implementing initiatives and possible solutions to these. Discussion will take place in small group settings, drawing on peer review and feedback from carers present, which are two of the feedback mechanisms Maroondah AMHS has employed in tailoring services for families and carers. CONCLUSIONS This workshop focuses on one services approach to developing a range of carer

supports in collaboration with carers. As a service provider, a major challenge we have encountered is in making carer centred programs an essential part of everyday practice. We invite other interested service providers and carers to join us in better addressing the needs of carers of people with a mental illness.

250 Paper: BUILDING THE BRIDGE BETWEEN THEORY AND PRACTICE; MEASUREMENT AND RESEARCH IN PSYCHO-SOCIAL REHABILITATION. Mara Pacers, Many theories and models exist about the best way to provide psycho-social rehabilitation, and often the reality and practicality of day-to-day practice is hard to reconcile with the ideals expressed in models. As a result the "theory/practice interface" is often a challenging zone for practitioners in psycho-social rehabilitation, especially when you add on the dimension of measurement of success and outcomes. We have addressed this issue head on at Prahran Mission where we have developed a comprehensive system encompassing 6 different types of psycho-social rehabilitation program. The programs involved include; Second story structured day program, Open House drop-in program, Ethnic Mental Health Outreach Program, Mothers' Support home based outreach program, Job Supply personnel open employment program and the café vocational training program. Four years ago we began exploring definitions of service and intervention types, transposing theory into work systems and practice guidelines and then developed a specific model of operations. Following on from this we developed a system of program evaluations. One of the most exciting and significant achievements through this process was the development of a complex client research data-base. The PSRP data-base has now been in operation for a year, with detailed records of almost 2000 clients. Many significant trends and indicators are beginning to emerge, especially with regards to the efficacy of particular interventions when applied to particular client goals.The paper will explore the steps taken to apply a systematic approach to program design, with a view on integrating theory and practice, as well as exploring fundamental questions of measurement, and finally will present the initial findings from the PSRP database

251 Workshop: TRAINING HEALTH PROFESSIONALS IN SMOKING CESSATION FOR PEOPLE WITH A MENTAL ILLNESS Kristen Moeller-Saxone Diseases caused by smoking are the second major killer of people with a mental illness. Despite the recent federal quit smoking campaign smoking rates among people with a mental illness have remained at over three times that of the general community. This could be due to a number of factors such as a lack of resources and support designed to help people with a mental illness to quit smoking. The SANE Smokefree Kit is one of the first smoking cessation group programs for people with a mental illness to be developed in the world. It was launched in July 1998 and there has been considerable interest in the program from consumers, carers, mental health and smoking cessation professionals across Australia. During the research phase of the Kit it was discovered that many health professionals were uninformed or even misinformed about the issues surrounding smoking cessation for people with a mental illness. Research indicates that some of the barriers to mental health professionals offering smoking cessation interventions to people with a mental illness include perceived lack of motivation to quit smoking, lack of counselling expertise by mental health professionals and lack of community support for quitters with a psychiatric disability. However, smoking cessation services have reported an increase in interest from people with a psychiatric disability. Both telephone counselling services and smoking cessation group programs are experiencing increasing participation by people with a mental illness. Health professionals providing these services also report a lack of expertise and confidence in dealing with mental health issues. Therefore training days for mental health professionals and smoking cessation counsellors have been held to deal with these issues. This workshop will include a report on the training days held for health professionals in three Australian states as well as presenting an introduction to the issues covered during the training.

254 Paper: "ISSUES IN THE EMPLOYMENT OF CONSUMERS IN THE MENTAL HEALTH WORKPLACE", Pip Matthews, Ani Southern Their paper will refer to real experiences of workplace innovations, creativity in management styles, co-worker issues, dreams that failed and dreams that became realities - providing examples from a range of workplace settings from a consumer employee/manager perspective. Also the presenters will outline considerations in consumer employment/management within the presenters' current work environment at the Mental Health Foundation. The aim of this paper is to provide an opportunity for delegates to explore other realities in terms of the employment of mental health consumers and issues facing their managers in creating an employment environment based upon realistic goals that nevertheless are still underpinned by the ideals which inform funding contracts, clinical training and development and family/caregivers needs

255 Paper: CONSUMERS AND CO-RESEARCHERS: A COLLABORATIVE APPROACH BY TOWNSVILLE INTEGRATED MENTAL HEALTH SERVICES AND CONSUMER ADVISORY

GROUP Sharon Harding, Rob Smythe, Catherine Clements (Schubach), Bettina Denham, Arthur Pickles, John Allan This study reports an innovative collaboration between Mental Health Services and Consumer and Carer Groups to evaluate satisfaction experienced by past and present residents of an inpatient rehabilitation unit and their carers. The impetus for the research came from the local Consumer Advisory Group, who devised the basic research questions and the outline of the satisfaction survey instrument. Mental Health Services employed a consumer and a carer co-investigator to work with senior staff members to complete the methodology and train consumer volunteers as interviewers. Face to face interviews were conducted with residents; carers responded to a written questionnaire and attended a focus group. All fifty consecutive past and present residents were approached and 43% of residents and 32% of their carers responded. Consumers tended to be globally more satisfied than their carers. Consumers gave more emphasis to the psychological aspects. The carers emphasised the clinical aspects of the program. Important coincidental findings were the skills developed for the consumer co-investigators and their use of intersectorial links to facilitate a smooth implementation. The role of consumers as researchers is critically appraised. This study may be criticised for using non-standardised instruments and retrospective data. However, such shortcomings do not detract from the significance of the benefits obtained by empowering consumers and carers of the service to form true partnerships with mental health services and participate in research where their own questions about services can be answered after the 10B Affair in the 1980's.

257 Paper: THE SOUTH EASTERN SYDNEY CONSUMER NETWORK DEVELOPING PARTNERSHIPS, EMPOSERING CONSUMERS M. O'Donnell, J. Sommer,S. Watson, S. Potma, T. Kessel, J. Namey, S. Tonilo,C.L. Fong The South Eastern Sydney Consumer Network (SESCN) primarily aims to provide a way for people living with mental illness to meet and support one another. It also aims to provide opportunities for consumers to learn about their rights and responsibilities, increase their knowledge of the consumer movement and to participate in the delivery of mental health services. Consumer positions are funded by the Area Health Service to promote the Network, develop the role of consumers in the delivery of services and explore ways of enhancing partnership with mental health service providers. Since its commencement in September 1997 it has gradually developed a number of unique features. Consumers were initially involved in promotion and liaison activities and then convened forums to focus on consumer needs. Consumer-led and driven social and artistic groups were instigated. These included Art Attack, Creative Writing and Music and Performance groups. Consumer representatives involved in policy and planning activities developed Committee Link to network with each other, develop their skills and negotiate policies. An Advisory Committee comprised of consumers, NGOs and service providers was formed to enhance the spirit of partnership and cooperation and allow consensus decisions for future directions. Consumer Support Workers provide 1:1 support and advocacy services for consumers in hospital. Close liaison and debriefing with service providers enhances collaboration. Network assistants are employed on a casual basis to co-facilitate groups and provide back-up services when necessary. Consumers with specialized skills are contracted to enhance particular areas of need. The SESCN is a dynamic, evolving group attempting to address the challenges inherent in service participation and consumer empowerment.

258 Paper: SUICIDALITY AND CHILDHOOD TRAUMAA MODEL OF INTERVENTION FOR YOUTH AT RISK Patricia Westhead, Alison Asche, Kath Elzinga, Sandridge provides a three-stage residential and support program for homeless young people between the ages of 15 to 25 years. Most residents have experienced some form of trauma or severe disadvantage which has led to the development of suicidal ideation and/or self harm behaviour. Accomodation consists of Sandridge House, a 24 hour residential service, the Sandridge Flats, and an Outreach Service. The program is designed to 'hold' young people for significant periods (up to three years) to enable them to address their issues and to develop independent living skills. Set within a youth work context, the program emphasises the principals of acceptance, choice, personal responsibility and belonging, with a focus on developing relationships. Individual and group work works towards the minimisation of self-harm and at-risk behaviour, assists residents in exploring how past experiences impact on their present lives and helps to identify more adaptive strategies for coping with stress. Emphasis is placed on encouraging residents to take responsibility for the decisions which affect their progress through the program and beyond. The Sandridge Program has a commitment to maximising resident participation in decision making. Program policies and procedures are jointly determined by staff and residents and regularly reviewed. Whilst predominantly operating from client centred

principles, the Sandridge Program draws on a range of theoretical perspectives including Cognitive Behavioural, Gestalt and Solution Focussed approaches.

259 Paper: MOVING FROM DREAMS TO REALITY -A COMPREHENSIVE CONSUMER INITIATIVES PROGRAMME Katrina Hasleton, Peter Schaecken The 2nd National Mental Health Plan emphasises partnerships with Consumers and the need to entrench partnerships at the level of service delivery. Central Sydney Area Mental Health Service has implemented its 1996 Strategic Plan for the development of Consumer Initiatives. A comprehensive programme to promote consumer participation at all levels is in place. This paper will outline the current programme and discuss issues that have been encountered and addressed. Results of the evaluation of the Strategic Plan for the Development of Consumer Initiatives will be presented as well as the results of a staff attitudes survey. Partnerships between consumers and the Mental Health Service are well entrenched. Consumers are employed in inpatient and community settings to work directly with consumers to provide advocacy, peer support and positive role models. There are consumer run recovery and early intervention programmes. The consumer representative structure is well supported with consumer representative training, consumer forums and mental health training programmes now open to consumers to attend. The Area Mental Heath Service is moving towards consumer representation on all non clinical committees. Other major achievements of the Consumer Initiatives programme include: Establishment of a dual disorder support group. Brochures produced by consumers and staff about what to expect from services.Positive impact on self esteem and recovery of consumers involved in the programme. There have been significant issues for staff in the implementation of the consumer initiatives programme - eg. confidentiality, role confusion, feelings of threat. Strategies for addressing these issues will be outlined. Four perspectives will be covered - consumer, carers, staff and managers. What we want to achieve in the next three to five years is to create real avenues to recovery and quality of life for people living with a mental illness by: Strengthening consumer representation. Employing consumers in varying meaningful roles throughout the Area Health Service. Including consumers in the staff selection process.Consumers in mental health promotion work breaking down barriers in the wider community.

260 Paper: YOUNG PEOPLE'S MENTAL HEALTH AND DRUG USE PROJECT A DUAL RESPONSE TO A DUAL PROBLEM Elisabeth Barry, Shane Brown The aim of this paper is to describe the establishment of a new information, education and support service for young people with mental health and drug use problems. This project is employing two new people - a co-ordinator and a peer support worker to work within the existing agencies to provide a service to young people which is responsive to their unique needs, and to build bridges between drug and alcohol and mental health services. The objective of the paper is to provide information about how the service has been developed, to describe the partnerships formed, to outline some of the dilemmas the service has encountered and to discuss some of the strategies being used to address the challenges. This service is forging new partnerships in a number of ways: 1 A partnership between two non-government organisations -Richmond Fellowship (an organisation providing supported accommodation services for people with mental illness) and South Sydney Youth Services Inc (a community organisation providing services to youth). The combined expertise of the two organisations increases the comprehensiveness of the services provided. 2 A partnership between the expertise offered by the peer support worker (a person with consumer experience) and the co-ordinator (a person with project management skills) 3 Funding for the project has been allocated to Richmond Fellowship from the Commonwealth Department of Health and Aged Care to service the unmet needs of the target client group. This is an innovative funding a partnership as young people with mental health problems have traditionally been excluded from drug and alcohol services.

261 Symposium:MAKING USE OF IT—NEW APPROACHES TO COMMUNICATIONS IN MENTAL HEALTH Susan Noonan This paper aims to outline new approaches to communications which have recently been undertaken in Victoria. Harnessing advances in information technology, improved communications have been achieved in the mental health sector between government and service providers, consumers, carers and the general public, as well as between services and clients. In 1998 the second edition of the electronic version of the mental health services directory was released. Distributed on disk ready for downloading on individual PCs, the directory provides comprehensive contact information for clinical and psychiatric disability support services. Aimed at streamlining the referral process, the directory provides fast and accessible information via computer. Last year also saw the launch of the Mental Health Branch website. The website provides information for consumers and carers, service providers and the general public including facts about mental illness, the services directory, news and events content, policy and guidelines, and information about training and development. Updated regularly,

the website provides access to accurate and reliable information about mental health for all Victorians.A more recent initiative in which the Branch has been involved is the development of the Health Channel which is a comprehensive health and well-being website aimed at the general public. Although currently a tool for publishing reliable health content, future iterations will allow for electronic service delivery and will encourage interactive use. A further important tool which has allowed for improved communications between service providers and clients is telepsychiatry—the use of teleconferencing technology to deliver mental health services. Telepsychiatry was initially trialed through two pilot projects in 1994 and the success of these pilots led to the establishment of a comprehensive network of sites across the State in 1996. Currently Victoria's telepsychiatry network links 39 sites across the State, allowing for improved delivery of mental health services to rural communities

262 Paper: COLLABORATIVE NOTEWRITING FOR THE NEW MILLENNIUM Jayne Webster, Heather Clarke, This paper will discuss the benefits of collaborative note writing from the consumers of Work Rehabilitation Services perspective and how this approach assists with ensuring we are working from the psychosocial rehabilitation and recovery models focusing on the worker's needs as perceived by them. Work can be the final step towards and reaching one's potential. As a service we aim to model and mirror as much as possible the real working world, so that workers can make a successful transition to open employment.   Following a client centred psychosocial rehabilitative approach, focusing on the client's strengths, abilities and resources, rather than illness and disability, empowers the worker to gain employment. A collaborative monthly work feedback sheet focusing on the worker's work skills and habits was developed. The feedback sheet assists in establishing goals and identifying small steps that workers can take to meet their dream of returning to or entering the work force. This process is completed together by the worker and occupational therapist. Initially this process was introduced to decrease the time occupational therapists spent writing work assessments and progress notes. It became apparent early on that this process also raised worker's involvement in line with a recovery approach. A quality of service measure completed after 6 months confirmed a decrease in therapist administration time, and an improvement in therapists being more consumer centred and in tune with the worker's needs and goals. A further quality of service measure gathered consumer's perspectives on the monthly work feedback sheet. Independent consumer representatives carried out focus groups and questionnaires after one year of using the feedback sheet. Workers identified clear benefits of this process and changes were implemented to improve the process on the basis of the worker feedback.

263 Performance/Workshop DREAMS OR NIGHTMARES? TOKENS OR TYRANTS? - CONSUMER PARTICIPATION IN MENTAL HEALTH SERVICES Murray Garner, John Wells, Karen Wells, Brian Hayward, Lynne Ahkan, Linda Duncan, Steven Bryham From the "Benign rulers" of Day Activity and Rehabilitation centres to the sophisticated "Snake Oil" Magic Model Hawkers and skirmishing Prosumers, where does your organisation stand? consultation or condescension collaboration or control empowerment or erosion representation or rule reality or rhetoric partnership or power**2 Parts-Performance and Workshop: Performance** A series of short role plays challenge the audience- service providers and users alike, to compare their practices and structures. The "stage/setting" is a consumer visiting a range of community rehabilitation or recovery services to work out which they would like to attend. They arrive and knock on a door (a full size lightweight red door is used as prop) to a range of different scenarios which clearly (hopefully?) relate to the past and present including:" Apathy"- consumers, some with quite pronounced side effects/habitual behaviours, sitting around smoking (simulated unless setting allows!), bumming cigarettes off one another and the new arrival, drinking coke and cups of coffee, doing nothing and waiting for staff to cook lunch."Patronising/control"-consumers being "herded" by a benevolent but very controlling and paternalistic manager to get on the minivan to go to the museum because "that's what's on the programme for today". This is challenged by one of the consumers "why can't some of us stay here at the centre." This is not accepted by manager." Chaos"- a collective meeting at a consumer run service, where there is major conflict, people are talking at each other regarding their pet concerns e.g. smoking inside or not, MH staff allowed on site or not. The meeting dissolves into general personal abuse and some people walk off. "Theory"- Two people from overseas (unspecified) with the FOFARI (Forward Outcome Future Action Recovery Inventory) very best practice evidence based collaborative community development model, or as they sell it- "the Ferrari of recovery models". As consumers question, despite the hype, smiles and increasing jargon it becomes clear that this is not a series of ideas, principles and practices which can be used by local consumers to develop or improve services, it's all or nothing-this is The Way. "Tyranny"- a "prosumer" is speaking to a group of consumers and somehow as in George Orwells Animal Farm, power corrupts, and the "prosumer" is as condescending

and patronising as any "mental health professional" could be. "Query"- the door is turned to face the audience. The role players knock on the door, it opens and the role players ask the audience- "and what do *you* offer? These scenarios do not rely on scripts and are adapted, added to and exchanged up until the very moment of the presentation to also capture the content, activities and mood of the conference itself. They reflect consumer experiences and are generally played straight but "compressed". Sometimes exceptions are made where parody or sending something up might work better. This is reflected in the over the top use of jargon in "Tyranny". Laughter is generally a feature of our performances- even though we do not set out to achieve this- people often comment on their laughter as they recognise with some discomfort, familiar but "taboo" topics being portrayed. **Workshop** Following these vignettes and with people suitably challenged, audience conduct an exercise (small groups-as regions, countries, core business, cross sector-depending on audience size, makeup and preference)- where they are further encouraged to reflect on and address the barriers to participation that exist within their organisations- attitudes, behaviours and environments, look to their dreams and confront the realities. Following feedback and discussion this material is collated and available for all participants. **Freeze Frame Interactive Role Players-Background Information** Freeze Frame is a small and dedicated Auckland group of mental health consumers, workers and others who together perform role plays and other actions in order to educate, challenge, provoke and entertain people (including ourselves!) on issues pertaining to mental health, illness and the industry .In addition to our mental health, public health and social service experience, members bring role play, playback theatre, modern dance, sociodrama and group facilitation skills. Formed in 1995, we have retained a largely informal and low key structure and rely on word of mouth for promotion and performance opportunities. We receive support from Framework Trust in allowing us to use their premise free of charge for meeting and practice and the Mental Health Foundation of New Zealand who hold a contract with the Health Funding Authority which incorporates some Freeze Frame performance. Other than this we have no operational, infrastructural or administrative support. To date successful performances/contracts have included: Auckland North Shore Youth/Rangitahi Summit 1996 providing role plays as a focus for plenary session TheMHS Brisbane 1997 as performance only West Auckland Mental Health Support Trust (consumer run) Official Opening 1998National Project To Counter Stigma and Discrimination Associated With Mental Illness- National Providers Seminar, Rotorua, 1998-a series of running skits and song measuring the mood and actions over 3 days; HFA Northern Region sub-contract for 9 performances 1998-2000 Waitemata Health and Framework Trust- training for Community Mental Health Services, various 1995 to date including for Challenging Incidents and Clinical Action Planning Mental Health Commission- Launch of "the Map of the Journey - a travel guide for people on the journeys towards equality respect and rights for people who experience mental illness", 1998Relationship Services-Television New Zealand "The Good Morning Show", 6 consecutive weekly performances portraying poor and good couple communication, 1998Royal Australia & New Zealand College of Psychiatrists Conference, Hamilton 1998 portraying disciminatory behaviour of psychiatrists

264 Symposium :BRINGING THE SPIRITUAL INTO FOCUS: DREAMS AND PRACTICE, FROM RHETORIC TO REALITY Kevin Kellehear, Leonie Manns, Marie Greenall Aims: To share the experiences and perspectives of consumers, health care professionals and academics in relation to spiritual needs. To raise awareness of the gaps and inconsistencies in mental health care when it comes to understanding and caring for the whole person. To share ideas about ways to re-locate the focus of care, to ensure that the dream of being understood and providing understanding becomes a reality and, where the spirit is enriched and nourished. **Objectives:** For presenters and participants of the symposium to: share experiences and ideas about the nature of spirituality and its meaning in the face of mental distress and illness examine the presence or absence of care of the soul in mental health care discuss the notion of the wounded healer and how their experiences can promote healing relationships explore the rhetoric and the reality of education and training of mental health professionals in holistic care discuss ways to re-locate the focus of care, to ensure that the spiritual needs of the person are understood and appreciated identify ways to ensure that appropriate systems of and approaches to care are developed and practised. Unifying themes The importance of considering the experience and spiritual needs of the person. Other ways of knowing, forming partnerships with and responding to people with mental distress and illness. Challenging the rhetoric and current models of practice. Curriculum and service issues that impact on, influence and have the potential to change existing patterns of care. **Souled Out: The rhetoric and realities of preparing mental health professionals for practice.** This paper will explore the gaps that exist between the promise and the rhetoric and the realities of mental health care when it comes to addressing the spiritual needs of the person. As we hear and read more and more of the experiences of consumers of the services, the messages

are increasingly about the need to be understand for what is actually happening on the inside. Frequently, it is the internal world that is troubled. These experiences become translated as symptoms and pathology, which become the focus of treatments. But it is the pain of the soul that needs understanding and care…and healing. Most curriculum documents present models of care that are holistic. Yet the reality is that the focus of teaching and clinical practice is mostly a bio-psycho-social model of care, often with the emphasis on the biological. When it comes to addressing notions of the spiritual needs of the person, the reality is that at best it seems to dissipate, is translated as religion, is ignored, or at worst, totally denied. It seems that it has been souled out.To arrive at real partnerships in care, we need to re-dress this imbalance. We must find ways to move holism from rhetoric in the curriculum to reality in practice. We must confront the rhetoric, bring the spirit into focus and prepare mental health professionals who are encouraged to, and can work with the whole person, to understand the totality of their experiences and offer care that promotes and fosters healing. An appropriate place to start is with the education and training of mental health professionals.**The Way Forward Towards Holistic Care**The way forward in mental health service delivery is for all partners in the healing process is to work together to provide quality services, programs and initiatives that involve a full spectrum of interventions that will make it possible to reduce mental disorders, improve mental health and emotional and social well being. To take these processes forward it is imperative that opportunities are made for impacting on the many factors that are known to contribute to mental health and provide appropriate treatment. As practitioners and consumers we must learn to work together to ensure that a truly holistic approach is possible. There are many steps that need to be taken for this to happen to the consumer's satisfaction. Firstly the partnership must become more equal particularly in the understanding of what is meant by holistic care. We need to take some positive steps to reduce the power imbalance between both partners - the consumer and the healer. Some of the ways that this can happen is within the training aspects of nurses so that good (and varied) nursing practice is developed from the beginning. The practitioner needs to develop not only "listening" skills but rather true "hearing" skills. We need to learn to see each others truths which will not always be medical but will include such issues as spiritual and social contexts of the consumer's life. We also need to be able to face very early on ways of lessening the fear of becoming more involved with each other. Workers and consumers need to be able to step outside the current bio-medical model and move on to what is often called the spiritual model but which is more correctly the holistic modality of treatment. There is much talk today of mental health literacy but it is essential that this literacy and the mental health dictionary must be expanded beyond the current medical lexicon. When we speak of abuse within the system we must also consider the abuse of the soul.**The Wounded Healer: A Bridge to new Partnerships in Care.**This paper explores the powerful influence of spirituality within the healing relationship of all partners in mental health practice. Mental health care is a specialised area of health delivery that encompasses the therapeutic use of self as an essential underpinning of practice. However the authenticity of the practitioner's self may include the acknowledgment that their own past wounds can be a powerful healing modality when brought to the practitioner/consumer relationship with care and compassion. Through their own experiences of falling into darkness and non-being in which they lose their own sense of self, their own feelings, their own place in the world, wounded practitioners can tender a deeper and more intuitive knowledge and insight in their dealings with the inner aspects of self. In addition through their own journey of healing they can share with the consumer the process of finding some meaning in the experience. Each human being is unique with unique responses to life, therefore the art of compassion requires the practitioner to walk alongside the consume, not objectively directing or leading, but subjectively supporting them during the journey and the healing process. By respecting this uniqueness, wounded practitioners work primarily as catalysts to assist in drawing forth the healing from within the consumer rather than imposing treatment upon them. This becomes an extremely powerful form of spiritual healing and bridges new partnerships, a kind of shared journey built on mutual understanding, respect and experience. Through my studies in anthropology, eastern and western philosophy, psychology and nursing I have reached the conclusion that the notion of the wounded healer should not be viewed as a limiting factor within professional care. I will propose ways to acknowledge a higher spiritual level that translates the dream of soul, the breath of life, to the reality of mental health care

265 Paper: BEAR IN MIND:THE HEALTH AND WELL-BEING OF PEOPLE WITH ACQUIRED BRAIN INJURY Lea Kewish, John Wakefield, Ria Strong The words empowerment and enablement are becoming increasingly familiar to people working in mental health and disability services, but often these concepts are difficult for health care professionals to put into practice. This presentation describes the philosophy, the process and the outcomes of a project which used the principles of empowerment and

enablement to explore the social and emotional health needs of people with acquired brain injury. The Health and Well-being of People with Acquired Brain Injury project was managed by an occupational therapist using action-based research methods guided by the principles of:1. self-determination and enablement, through individual choices and participation in the project 2. group support, for personal validation and development of skills and knowledge3. empowerment, through participant control over the project's progress and outcomes4. support for well-being and well behaviour long after the official rehabilitation process The project had a number of positive outcomes, including the development of a self-advocacy presenters' kit, and the establishment of a self-advocacy and community education group, Bear in Mind. Materials developed through the Health and Well-being... project are now used by members of Bear in Mind to educate professional and community groups about the issues faced by people living with acquired brain injury. The group's powerful presentations focus on the psychosocial aspects of ABI-including depression and adjustment to loss, changes in relationships and friendships, social support, communication issues and self-esteem

266 Paper: FROM SMALL BEGINNINGS.THE GROWTH OF THE NGO SECTOR AND THE NEED FOR AN INDUSTRY REPRESENTATIVE ORGANISATION Barbara Anderson, Hugh Norriss, Julie Nelson, Margaret Beets The number and influence of NGO mental health community support providers in New Zealand continues to grow. It is estimated that each day around 4000 consumers/tangata whaiora receive services from 1500 people employed by 150 or more providers. The services generally range from residential rehabilitation through to home based support, and include an increasing number of kaupapa Maori services.NGO organisations are spread far and wide around the country. They range in size from just a volunteer committee with no paid workers through to national organisations that employ several hundred people. There are however common threads throughout the philosophy of all the organisations, including an understanding of community based models and working with people in a way that validates there own experience and background. The National Association of Support and Housing Services for Mental Health (HOMES) was established in 1993 in response to the need for this growing sector to work more closely together, identify common interests and communicate with stakeholders. The NGO sector is now positioned through its sheer size and influence to provide significant leadership in the mental health sector. Correspondingly HOMES is gradually maturing into the industry body for NGO providers. In response to feedback from its membership, HOMES sees the need to set up a more comprehensive regional network for providers, create information services on community support, initiate research on community support outcomes, produce an accreditation system for members, continue to problem solve issues affecting the sector through dialogue with government agencies, and educate politicians and the community on the positive benefits of community support initiatives. To fulfil these aspirations HOMES will need the support of the industry and to secure effective representation across the sector, particularly from partnerships with Maori provider groups and consumers. The multi media presentation from HOMES members traces and evaluates development from a small informal group of local providers to the present nationally representative organisation - and then looks to future challenges

267 Paper: RESEARCH FINDINGS ON HOMELESSNESS AND FLEXIBLE SERVICE DELIVERY IN INNER CITY MELBOURNE Joan Clarke, Nicky Bisogni Prahran Mission is an inner suburban multi-service agency with a history of innovative service delivery to people with severe psychiatric disabilities who are often rejected by other community service agencies and who are seen to fall through the gaps in our overall service system. Our recent experience has been that increasing numbers of these people are homeless and many are completely outside clinical and psychiatric disability support services. Prahran Mission, as a Mission, is well resourced for the provision of the basic necessities of life and due to homeless people congregating in the large ground floor area, has been able to flexibly respond to their needs for food, clothing and showers. It became obvious over time that the issues around shelter, or lack of, were complex and needed more sophisticated research. Funding was obtained from the Mercy Foundation and Department of Human Services for this research. The aims of this paper are to report on the above research and focus on the following:identification of the complexity of issues around psychiatric disability support and homelessness for adults in the context of an inner city suburb; identification of the various reasons for homelessness in relation to people with psychiatric disabilities in the context of an inner city suburb; identification of the reasons for the non use of specific psychiatric disability support services, both clinical and community ;details of the types of services consumers have identified as fulfilling their specific needs

268 Paper: CONSUMER PERSPECTIVES OF WORK READINESS: A COMPARATIVE STUDY EXAMINING THE RELATIONSHIP BETWEEN PRE-EMPLOYMENT AND JOBSEEKING

ASSISTANCE THROUGH SERVICE DELIVERY. Simone Waugh, Ursula Pethica Historically there has been a severe paucity of services which address pre-employment requirements for people with a mental illness who wish to ultimately access job seeking assistance through either mainstream or specialist agencies. This paper presents a differential analysis of consumer attitudes, values and beliefs concerning the factors surrounding work readiness - barriers to accessing employment services and achieving employment outcomes, self-assessment of assistance required prior to successfully participating in employment services, quantitative and qualitative assessment of consumer outcomes. The study focuses on two specialist services designed to offer assistance particularly to people with a mental illness; one that addresses the pre-employment needs and one that offers direct employment support. two questionnaires were developed to measure consumer perspectives with a subsequent statistical analysis of the raw data being applied.

269 Paper MEAT IN THE SANDWICH BROTHERS AND SISTERS OF PEOPLE WITH MENTAL ILLNESS RELATE THEIR EXPERIENCES   Garrett O'Dowd, Colin Riess This presentation aims to inspire and motivate mental health worker to include brothers and sisters of people with a mental illness in the spectrum of services they provide. The presentation will be helpful to workers who are aware of the need to support family members including brothers and sisters but feel they need more information and experience to do this well. It will facilitate access for service providers to valuable information about the impacts of growing up in a family in which a brother or sister has a mental illness. The presentation will utilise the experiences of a young siblings (15-19) support and information program conducted jointly by Bouverie Family Centre and Schizophrenia Fellowship of Victoria (SFV). The program was interactive and developmental and regarded the siblings as experts in their own fightback against the impacts of mental illness on their lives. Two group members will participate in the presentation. Specifically, it will explore: The issues for brothers and sisters of people with a mental illness fears and conflicts issues with their parents feeling 'caught in the middle' Steps to deal with and better manage the impacts on them clarifying boundaries identifying things to do to improve the situation Finally, a precis of the evaluation results will be given, and suggestions for further development of the ideas contained in the program.

271 Paper: STANDARDS IN MENTAL HEALTHCARE ARCHITECTURE AND THE IMPACT OF THE PHYSICAL ENVIRONMENT ON PATIENTS' RECOVERY PROCESS Emily McGuire Focus: The key topic for the paper will be the state of Mental Healthcare Facility design and the impact that the physical environment can have on the recovery process of people affected by mental illness. Analysis of the environment will be primarily from an architectural design perspective, with the needs of the end-users being considered. Author will overview briefly on background both personal and professional, which led to research in the field of Mental Healthcare Architecture.   "Few architectural environments are thought to have as great an impact on the well-being of inhabitants as do mental-health centres… However, despite their importance, the provision of proper care for the mentally ill has been a problem for centuries."Spivack, M. *Institutional Settings: An Environmental Design Approach.* New York: Human Sciences Press Inc, 1984Research shows that the state of a patient's physical environment can facilitate or be detrimental to the recovery process. A hospital environment in a depraved state, lacks certain behaviour settings and has been proven unable to support the great range of human behaviours associated with the recovery process, resulting in a severe personal, social and psychological loss for the patient. An overview of the adequacy of historical and contemporary examples of hospital settings will be given. As well, an explanation of how the design of a hospital environment can impact on the behaviour, experience and well-being of its users and inhabitants will be given through an analysis of the architectural design elements within certain environments. The design elements include such things as colour, light, texture of surfaces, materials, spatial arrangement, gardens, openness, security, private and public spaces and context. This will assist in recognizing the importance of how certain elements in architectural design can effect the character of an environment and the kinds of behaviour it will support, and the psychological implications and sensory distortions patients may experience as a result. It is hoped this information may provoke an awareness of the sensitivity of a patient's response to their environment. By acknowledging the impact the quality of a patient's environment can have on their behaviour, care and rehabilitation, the need for a revolutionary approach to the future design and modification of existing mental healthcare facilities may be addressed. The author wishes to express the hope that by leadership shown by a team of diverse professionals involved in mental healthcare, issues of community stigma toward mental illness may be addressed, and a compassionate, humane and informed approach may be reached in the design of mental healthcare architecture and the provision of services for care of the mentally ill.

272 Paper: PARTNERS IN SHARED CARE : THE CONSUMER AND THE GENERAL PRACTITIONER. Lynette Joubert, Graham Meadows, Voula Adamopolous Aim: Is the reality of the CLIPP (Consultation Liaison In Primary-care Psychiatry) program a realisation of the dreams of the consumer, with the transfer of care to a GP being a positive step in the recovery process? We present baseline and second assessment data of 62 clients in shared care arrangements with General Practitioners in Northwest Melbourne. Method: Repeated measurement of health and satisfaction outcomes, using the HoNOS, Role Functioning Scale, Life Skills Profile, GAF, SF-36 and consumers' expressed levels of perceived met need measured with the Perceived Need for Care Questionnaire (PNCQ).Results: Continuity of care has been well maintained in this shared care setting. The PNCQ finds that most perceived need for mental health care is met. The LSP generally showed impairments in domains of social contact, communication and responsibility, but with stability of these measures. On the RFS there was a high frequency of dysfunctional scores in the areas of work and immediate and extended social networks but again the pattern was of stability in this measure. HoNOS scores reflect low symptomatic status with affective symptoms the most frequently endorsed. Some clients are reporting more affective symptoms on second assessment. The SF 36 showed some positive changes in self perceived physical health. Discussion : This shared care setting has demonstrated the ability to maintain essential elements of continuity of care and to generally meet needs for maintenance of remission of psychotic symptoms. There are some benefits to physical health. The findings emphasise the need to maintain vigilance for co-morbid affective symptoms in such settings. For most consumers the passage into a shared care setting has been acceptable, with continued meeting of needs for mental and physical health care.

273 TOWARDS NEW PARTNERSHIPS: NATIONAL MENTAL HEALTH STRATEGY FRAMEWORK FOR ACTIVITY AND CONTINUING REFORM IN THE DELIVERY OF MENTAL HEALTH SERVICES FOR AUSTRALIA'S DIVERSE CULTURAL AND LINGUISTIC COMMUNITIES Conrad Gershevitch, Abd-Elmasih Malak The landmark National Mental Health Strategy – a partnership agreement between all levels of Australian governments to work together to reform the mental health sector - has been renewed by Health Ministers with the 2nd National Mental Health Plan funded to June 2003. Under the Plan, better ways of meeting the often complex mental health needs of Australia's diverse communities remains a priority. This priority was recognised in the first phase of the Strategy and supported by the establishment in 1995 of the Australian Transcultural Mental Health Network (ATMHN). As well as contributing to transcultural mental health policy directions under the Strategy, the ATMHN provided for the first time a national information service on transcultural health which included a library, website and clearing house.The ATMHN's contribution to developing a partnership approach with states and territories and providing information on transcultural mental health under the first phase of the Strategy has been recognised. It is anticipated that the ATMHN will continue to play a key role under the 2nd Plan. Network members, consisting of representatives from states and territories, consumer, carer and non-government organisations have identified the goals and directions for the next two and a half years. This information session will provide insight to the partnership activities from a national, state and project perspective. It will:examine how the ATMHN fits within the Partnerships in Service Reform agenda of the 2nd National Mental Health Plan from the national and Commonwealth perspective; illustrate how the Network is operating at the practical level as well as report on the agreed priorities to be pursued in the years ahead from the manager of the ATMHN; and report on one of the ATMHN's national communication project initiatives from the state manager. NMHS material and contact information on the 2nd National Mental Health Plan, the ATMHN and its various projects, will be made available to participants.

274 Paper: PRIMARY MENTAL HEALTH CARE (PMHC) STRATEGY Leonie Young, Conrad Gershevitch A research project began in 1995-96 under the National Mental Health Strategy (NMHS) which examined the roles of general practitioners (GPs) in primary mental health service provision. The project assessed the education and training needs of GPs in fulfilling these roles, and assessed the most productive service linkages between GPs and psychiatric services. Following the publication in late 1997 of the resulting report, *Primary Care Psychiatry: The Last Frontier*, stakeholders provided advice on priorities for implementation which led in June 1998 to a *Proposed Implementation Strategy*. A general approach was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) National Mental Health Working Group in late 1998, with nine identified specific priority areas for a Primary Mental Health Care (PMHC) Strategy. Following further stakeholder consultation and refinement of the approach, the Minister for Health and Aged Care, Dr Michael Wooldridge, approved $3million in March 1999 for a systematic process of educating GPs in mental health care and improving links between GPs and public and

private psychiatric services. An update will be provided on this process and other priority areas of the PMHC Strategy

275 Paper: YOUNG PEOPLE & BUREAUCRATS - BUILDING BRIDGES FELICITY ENGLE SUICIDE IS THE SECOND BIGGEST KILLER OF YOUNG AUSTRALIANS AGED 18-24. THE WAY THIS IS BEING DEALT WITH IS SOMETHING THE PRESENTERS WISH TO CHALLENGE. Felicity Engle It is our belief that the rate of youth suicide will not decrease until there is clear communication, respect and partnership between young people, bureaucrats (our definition of bureaucrat is the majority of people over 25 who deal with young people) and service providers. Policies and strategic goals need to be translated into real services on the ground that mean something to young people. This is only possible if meaningful partnerships are developed. Young people are a special group of the population, and current services don't seem to be addressing their needs. Young people need to be involved with the conception, planning and implementation of measures which are hopefully going to increase their life expectancy. It is one thing to consult with young people but it is another matter to work in alliance with them. Young people know what does and does not help them. It is our belief that all young people need is to be given the space, time and encouragement to test their wings and find out what works best for them. It is by making mistakes that we learn what is and what is not right for us as young people. Young people are individuals and need more than textbook solutions. All people are unique for a reason - if everyone were exactly the same the world would be a very boring place. We would like to see changes to the way bureaucrats work on a national, statewide, department, team and individual basis. Our workshop will introduce participants to some of the changes we as consumers wish to see, by the use of a range of activities

276 Paper: HOMELESSNESS, MENTAL HEALTH AND SUICIDE PREVENTION: A YOUNG PERSON'S PERSPECTIVE Lynessa Garland The aim of this workshop is to give an understanding of what it is like to be a young person in the 1990s. Being young and homeless, while being emotionally unwell is no easy task in the present day and age. Fear goes hand in hand with being young. Being unfamiliar with the country, the people in it and what might happen when a person is fearing an event that may or may not happen takes its toll on the mind and body. Extreme fear can promote stress and feelings of being physically unwell, for example headaches and stomach pains. The above is based on my personal experience and not on scientific experiments. Once again, based on personal experience, extreme fear can also lead to feelings of paranoia. In turn, this has led to hearing voices of "people out there" who I perceive would harm me. All of the above became much worse for me when it was mixed with becoming homeless. I believed I had reason to fear society, as the basic necessities of life ceased to be provided by my family: food, clothing and a roof over my head. This led to losing what trust I may have had, subsequently withdrawing into my shell. Being in the situation of experiencing both homelessness and mental health concerns meant greater difficulty accessing appropriate, or even inappropriate, services. It seemed that services for people experiencing both homelessness and mental health concerns, either didn't exist or were hidden away. This led to feeling as though I didn't belong in society. The combination of fear, loss of trust, and feeling as though I didn't belong in society led to me thinking of suicide. I went on and made several suicide attempts. I realised what "help" I was being given with my suicidal feelings was inappropriate. From here, I went on to develop my own ideas of practical suicide prevention that saved my life. All of these ideas can be found in my soon to be published book, titled "Daring to Be Different: Suicide Prevention My Way

277 Paper: THE QUEENSLAND COORDINATING DIVISIONS MENTAL HEALTH PROGRAM: AN EXAMPLE OF THE DEVELOPMENT OF EFFECTIVE PARTNERSHIPS BETWEEN GENERAL PRACTICE AND MENTAL HEALTH SERVICES Grace Groom This paper describes the Queensland Coordinating Divisions Mental Health Program which commenced in September 1998. The Program, which is funded by the Queensland Divisions of General Practice (QDGP), involves the provision of support to all Queensland Divisions with the development, implementation and evaluation of mental health programs and facilitates integration between general practice, mental health service providers, consumers, Queensland Health and the Commonwealth Mental Health Branch. The Program is overseen by a State Steering Committee and reports to the QDGP on a quarterly basis

278 Paper: SHARED MENTAL HEALTH CARE: FROM VISION TO REALITY Stephen Wild, Grace Groom, John Davies, John McGrath, Trish Nolan This paper describes a shared mental health care program between the Logan Area Division of General Practice and the Logan-Beaudesert Mental Health Service. The program involved transferring the care of 22 seriously mentally ill consumers into the care of six GPs who had completed additional mental health training. A Case Manager was seconded from

the Mental Health Service to assist the GPs with the care of the consumers. Preliminary findings indicate a high level of consumer and GP satisfaction, detection of previously undiagnosed physical disorders, improved compliance with treatment and medication regimes and cost savings due to reduced rates of hospitalisation.

280 "WHAT IS THE FUTURE FOR ABORIGINAL MEN IN AUSTRALIAN SOCIETY? Michael Wright Introduction As Australia approaches the next millennium it will need to respond to a number of social issues that are and have been present within the Aboriginal community for the past 200 years. My name is Michael Wright, and I am a Nyoongar man from the South West region of Western Australia. I am currently employed at the Derbarl Yerrigan Health Service managing the community based mental health inreach program, the Derbarl Yerrigan Health Service Mental Health Support program. This paper will explore the issues that are currently confronting Aboriginal men in this society. These concerns are familiar to all of us, as they include many of the issues that are at the interface of our daily work practices. They involve both mental and physical health related concerns. On average Aboriginal men live 20 years less than their non-Aboriginal male counterparts, they are dying prematurely from preventable illnesses and furthermore, Aboriginal men are more likely to be incarcerated sometime during their lifetime. The other major concern that has had serious consequences for Aboriginal men is the continuing rise in unemployment in their communities. The impact of this social problem has been the limitation of economic independence for Aboriginal families. This has meant that Aboriginal men have had to adjust and change their role from a being the warriors in their communities to having to become dependant on the state and its welfare system. What are the causes for this continuing trend? This paper will explore the underlying reasons that are the contributing factors for this current trend. This paper will explore by providing examples that will assist mental health practitioners to develop intervention strategies to respond to the immediate and long-term needs of Aboriginal men. Finally, it is imperative at this point in the history of Australia, that an assertive and collaborative community approach is developed to address the appalling social situation that continues to manifest itself within Aboriginal Australia

281 Paper: SURVIIVING AND THRIVING ..KEY FACTORS IN THE DEVELOPMENT AND CONSOLIDATION OF A RURAL/REMOTE COMMUNITY MENTAL HEALTH SERVICE Carol-Ann Stanborough What are the tenets of an effective Community Mental Health Service?? How do you ensure that the service is appropriate, accessible and based on the needs of the communities it serves?? How do you recruit and retain skilled, enthusiastic staff ?? How do you achieve these goals with limited resources in a climate of economic rationalism?? What are the community and other professionals expectations of such a service?? Reflections of a multi disciplinary Team Leader serve to describe the path of a community mental health service which has grown from surviving to thriving. The team sits within a broader Community health team and service. The experience has demonstrated the value of this positioning but has also highlighted the advantages and disadvantages for managing and leading such a broad team. Services are provided to a vast geographical region which encompasses approximately 98% of South Australia. Diverse cultures and lifestyles are features of the population and extensive travel and liaison forms a large part of a community mental health workers role. Lessons learned and principles developed are explored in order to give insight to others who are working to address similar questions to those posed. Profiling examples of tools adapted and produced, systems of work created to support and enhance service provision and sharing of lived experience offers the opportunity for learning from mistakes made and successes gained. From the outset this is a conversation which aims to generate recognition of the challenges faced by community mental health workers in their efforts to provide services whilst also ensuring they maintain their own mental health.

282 Workshop 'COMMUNITY DEVELOPMENT – CAN IT WORK WITHIN A CLINICAL ENVIRONMENT' WORKSHOP Joyce Apap, Judith Morrison This workshop will seek to explore how the principles /values of Community Development, such as consumers' personal empowerment and implementing changes to a system can work within a Mental Health Clinical Service environment. The workshop will address; 1.Historical Overview of Community Development –presented by Joyce Apap 2. What is Community Development in today's political and social climate – presented by Judith Morrison 3. Community Development practices and challenges within a Mental Health Clinical Service - presented by Joyce Apap and Judith Morrison The proposed format will use the attached presentation to focus discussion. The workshop will be participatory . Overheads will be used for points of discussion as well. The overheads will come from aspects of the written presentation

283 Paper: NUTRITIONAL MANAGEMENT IN MENTAL HEALTH REFORM Sue Race, Fay Harmsworth, Margaret. Way,Bee. Mitchell-Dawson Mainstreaming has been an aspect of the agenda

for Victorian mental health reform that was to provide amongst other things, services that are responsive and accessible to the population it serves. During the initial period of change a significant amount of time and effort was dedicated to establishing new structures and processes to accommodate this reform. As a result some key services to the Psychiatry and Psychology Clinical Service Unit (P&P CSU) became fragmented over time and as a result significant gaps in some services arose. Dietetics was such a service that suffered. This is also complicated by the fact that the nutritional well being of people affected by a mental illness is frequently overlooked. The management team of the P&P CSU identified this problem and in order to address these issues a review of nutrition and dietetic services was initiated. The purpose of the review was to define the nutritional needs of the current population managed by the P&P CSU, and then propose the range and types of dietetic services required to meet the current and future needs of all patients serviced by the CSU. An extensive consultation process incorporating a patient profile and food service needs assessment comprised the key methodology for the review. Patient profile assessments of all units identified a need for adequate dietetics services for psychiatric patients. It was found that between 70 to 84% of patients admitted under the CSU had a nutrition related problem. These problems ranged from obesity to undernutrition and also included a coexisting medical condition requiring nutrition intervention, such as, diabetes or coronary artery disease. Service development needs were identified in the areas of clinical care and food services. In order to provide an appropriate and adequate service a base dietetic staffing level was recommended. Strategies for providing the clinical dietetic service and improving the provision of food service were documented in a staged implementation plan. The outcomes of this review include: An improved understanding of the role of nutrition in the management of people affected by a mental illness and, Improved access for people associated with the mental health services of the Austin and Repatriation Medical Centre to dietetic services and appropriate nutritional management.

284 Paper: STRESS AND THE DISABILITY SUPPORT WORKER EXPERIENCE Carolyn Perry
The aim of this paper would be:1.To raise awareness of the stresses experienced by psychiatric disability support workers in the community.2 To highlight the need for a variety of responses from individuals, staff teams and organisations to assist support workers manage stressful situations in order for workers to continue meaningful work with clients. An Awareness of Disability Support Worker Stress The types of stresses experienced by support workers would be presented based on research interviews with support workers. Six major themes would be covered. These would be stresses associated with: Working with individuals with unusual or challenging behaviours. Working with individuals who have intense or high-level support needs. Stresses associated with the nature of the work eg shift work, unpredictability. Investing energy in trying to contain stress. Working in conflictual team settings. Organisational/management issues. Providing a Response to Support Worker Stress The types of responses that support workers have found helpful and not helpful would also be presented based on the results collated from a support worker questionnaire distributed in the Brisbane metropolitan area. Major themes would include: Communication strategies eg. supervision, debriefing, counselling Organisational responses eg developing an Organisational Stress Management Plan. Summary An explanation of this research would then be given to describe how this work has lead to a new nationally recognised short course entitled Responding to Stress in Disability Support. This course is designed for all workers in the disability support field.

289 Paper/Workshop WHOSE DREAMS? WHOSE REALITIES? Julie Johnstone The Mental Health Services Conference Inc. of Australia and New Zealand (THEMES) September 22-24 Melbourne Convention Centre The Narrative Subject: Transforming Acute Psychiatric Services? despite the implementation and completion of the first National Mental Health Strategy, consumers of acute psychiatry continue to describe services as not only failing to meet patients' needs, but as harmful. This problem might be addressed by asking: how is the subject or patient conceptualised in acute mental health services? I suggest that if biological psychiatry is the only means to address the patient it is limited. I further suggest that another strategy to incorporate the consumer perspective is necessary to acknowledge the relevance and legitimacy of patient narratives or consumer perspective in the provision of services. This paper looks at such an alternative interpretative conceptualisation of the subject and narrative methodology in the work of Taylor and Ricoeur. What this would look like, how it would be introduced, and the problems with implementing such a conceptual shift in acute mental health services I discuss in the context of the Second National Mental Health Policy's outcome measures.

290 Paper: MOVING LONG STAY PSYCHIATRIC PATIENTS INTO THE COMMUNITY: THE IMPORTANCE OF LIVING ENVIRONMENT John Farhall, Tom Trauer, Peter Cheung, Richard Newton Victoria has now replaced its stand alone psychiatric institutions with a range of hospital and

community psychiatric services. Community Care Units (CCUs) are 20 bed clinically staffed rehabilitation services in the residential suburbs which have replaced long term open wards. Since 1995, a major evaluation project has been studying the outcomes for 125 patients from an institution (North Eastern Metropolitan Psychiatric Services) who were intended to go to one of seven new CCUs. Data was collected pre-move, one month post-move and again one year later. Comprehensive assessments included psychopathology, disability, aggressive behaviour, quality of life, attitudes to the change, and satisfaction with accommodation and services. The views of carers and staff were also sought. We are now in a position to report results from several sources of information. Results from profiles of the environments, consumers' preferences, quality of life interviews, ratings of psychopathology and personal functioning, aggressive incident reporting, and staff views are presented. Findings revealed that the community settings had far less institutional practices. Consumers had strong preferences for their new community placements. Quality of life interviews showed that the primary subjective changes were in the area of living situation. On average, measures of psychopathology (the Positive and Negative Syndrome Scale, PANSS) showed no change in the severity of psychiatric symptoms, and neither did a measure of personal functioning (the Life Skills Profile, LSP). There was a significant reduction in the proportion of patients registering aggressive behaviours. Changes in staff's perception of their own stress and rehabilitation practices in their place of work will also be reported. Greatest change was observed in both objective and subjective ratings of living environment, while measures of psychiatric symptoms and personal functioning changed least. Thus it appears that the major impact of the transition from hospital to community arises from the change in living arrangements.

293 Paper: MENTAL HEALTH CONSUMER WHO GRADUATED WITH PhD RECENTLY.Error! Bookmark not defined. Noel Smith Having been diagnosed with severe schizophrenia before I commenced my tertiary studies, many persons, including the psychiatrists who treated me, were quite surprised that I was able not only to successfully complete my Honours and Masters degrees in science, but also (more recently) my PhD. I also held down a research position at University in computing and psychology, having gained my qualifications, despite my disabilities. More generally, I believe, it is becoming increasingly accepted, that schizophrenics are capable of returning to significant tertiary studies after their illness has been stabilised by medication. However I believe that this can only be achieved if they are provided with a supportive and non discriminatory work environment. I consider the kind of environment and support which enabled me to make these achievements were firstly the support organisation which I subscribed to throughout my studies, namely GROW, which is a self-help support organisation for mental sufferers (of which I am currently an Organiser in the Geelong region); secondly, the University which I attended, namely Deakin University, has a policy of non-discrimination towards persons with disabilities; also I believe that the community spirit of this university shows a greater degree of tolerance to persons with disabilities than other (educational) organisations.I believe the notion that schizophrenia is primarily a "thought disorder" by many health professionals needs to be seriously questioned. There can be no doubt that I fitted in well with the current models of schizophrenia when off medication, nor can there be any doubt that I respond well to schizophrenic medication and no other. If then schizophrenics can be considered to be sound thinking responsible persons, after they have been treated and rehabilitated there is every reason to accept them (or us!) into responsible pro-active positions in the work force .I am present finding it difficult to secure regular employment, probably, I believe, because many people in the Geelong community are aware that I have a history of mental illness, and in any case I twitch and shake as a result of my medication indicating to employers at interviews that I have some kind of nervous disorder. I am currently completing my Master of Education degree and tutoring Aboriginals part time. However I feel I should be given the opportunity to contribute to the decision making bodies in Human Services in a more direct and formal way, given my rather unusual story.

294 Paper: THE FESTIVAL FOR HEALTHY LIVING - A MENTAL HEALTH PROMOTION STRATEGY Harry Gelber, Anne Boscutti Almost one in five children and adolescents in Australia are effected by mental health problems with at least half showing impairment in schooling and social development. Such mental health problems are now known to be associated with vulnerability in development years and greatly heightened risk of mental disorder in adult life. Therefore, it is critical that a variety of strategies are developed by services. These strategies should build on strengths of the children, adolescents and families and promote the importance of Metal Health prevention within the community, taking into account the policy focus of the second National Mental Health Strategy. The involvement of schools in a Healthy Living Festival is being developed as a mental health promotion \ early intervention strategy. It provides an opportunity for the Education and Metal Health Sectors to collaborate in developing

a performing arts program which encourages children and adolescents to think about mental health issues and avenues for enhancing resilience and well being. This paper will outline the first phase of a collaborative initiative between the Child and Adolescent Mental Health Service (CAMHS) and the Department of Education. The Festival for Healthy Living is an innovative project using drama to facilitate student exploring of metal health issues with a focus on finding solutions, promoting wellbeing and enhancing resilience. The process also directly addresses stigma related to mental health problems and raises the profile of metal health as a continuum, which includes illness at one extreme and well being at the other. Exploring these concepts with children and adolescents whose attitudes are still developing provides a window of opportunity to promote understanding before stigmatizing stereotypes are well established. The paper will give an overview of the philosophy and key features of the Festival with feedback from the initial evaluation including video excerpts

296 Symposium: INTEGRATED SERVICE PSYCHIATRISTS MEETING Alan Rosen, Helen Herrman, Nick Judson Comprehensive Area Service Psychiatrists (CASP) Special Interest Group has been meeting and running seminars for many years in NSW. CASP functions as an independent political advocacy body as well as a support group and information exchange network for psychiatrists working full or part time in, or consulting to, the public sector. At THEM.H.S 1998 in Hobart, an informal meeting of psychiatrists involved in such services, from different parts of Australia and New Zealand, resolved that we should have a network meeting twice a year, at both THEM.H.S and the RANZCP Congress. This will be the inaugural formal meeting of this network. The agenda for this meeting may include reviewing The Role of the Psychiatrist in the Interdisciplinary Team; and the potential impact of partnerships between public, private and non-government psychiatric services at a local or area level; and other factors pertaining to sustaining the involvement psychiatrists have in local mental health services.

297 Symposium: STIGMA SYMPOSIUM WPA Steering Committee, Alan Rosen, Liz Newton, Barbara Hocking, Michael Shortland This Symposium will be opened by members of the International Steering Committee of the World Psychiatric Association "Program for Reduction of Stigma and Discrimination because of Schizophrenia", as delegated by Professor Norman Sartorius. They will launch the World Psychiatric Association (WPA) package concerning Stigma in Schizophrenia and will give a presentation about the materials and manuals contained in the package. The launch and presentation will be followed by several speakers. Alan Rosen will chair the Symposium. on Stigma "Killer Inmates Fleeing Hospital" – Fears and Reality Liz Newton and Alan Rosen Attitudes to the Use of Electroconvulsive Therapy in Young People Garry Walter The SANE Community Awareness Campaign *works with* "Home and Away". Barbara Hocking Australian and New Zealand Psychiatry at the Movies. Michael Shortland Open Discussion. Chair: Alan Rosen and Garry Walter. Alan Rosen, Royal North Shore Hospital and Community MHS and Universities of Sydney and Wollongong Garry Walter, Rivendell Adolescent Psychiatry Unit plus University of Sydney Liz Newton, Ryde Mental Health Services, Sydney Barbara Hocking, Executive Director of SANE Australia, Melbourne Michael Shortland, Historian and Philosopher of Science, Melbourne International Delegates of Professor Norman Sartorius, President, World Psychiatric Association, Switzerland Educational Objective: To define the social determinants of stigma in mental illness and practical strategies to successfully challenge it in our communities.1. "KILLER INMATES FLEEING HOSPITAL" – FEARS AND REALITY iz Newton, Alan Rosen The title of this paper is a quoted headline from a local newspaper printed a few days after a group of long-stay psychiatric inpatients moved to the community. If the local community expressed no alarm prior to their discharge, they certainly did once this negative press was released. Developing and achieving a new and acceptable identity in society for individuals who have spent

the major portion of their adult life in an institution is difficult. Hatfield and Lefley (1993:144) describe obstacles to this process whereby "some of these barriers have their origins in the unique experiences of mental illness and their sequel, and some in the ways that our society responds to them". The invisible stain or blemish, that is, the psychiatric stigma, following long term institutionalisation is a legacy of a system imposed by mainstream society that considered mentally ill people a forgotten sector of society: 'Out of sight out of mind'. This paper examines some of the fears and realities encountered by both mentally ill individuals and the wider community connected with the deinstitutionalisation experience. Given adequate supports, reintegration and reconnection within mainstream society is achievable and desirable for people who had prolonged hospitalisation history.   Minimising societal rejection, ignorance and irrational fears requires a committed and multifaceted approach to change established attitudes, thus enabling the successful reintegration of deinstitutionalised people.2. "ATTITUDES TO THE USE OF ELECTROCONVULSIVE THERAPY IN YOUNG PEOPLE" Garry Walter ECT in young people is an uncommon and controversial treatment. There is increasing knowledge about its effectiveness and safety, but the treatment remains highly stigmatised. As one trenchant critic has declared, "ECT administration to one child or adolescent per year is one too many". In this paper, clips from two movies, *Ordinary People* and *Return to Oz,* are shown which capture public sentiment about ECT in young persons. This paper also examines the recent literature about ECT in the young, including the attitudes of health professionals, recipients and recipients' families regarding the treatment. Some of the possible reasons for antipathy towards the treatment are explored.3. "THE SANE COMMUNITY AWARENESS CAMPAIGN *WORKS WITH* "HOME AND AWAY" Barbara Hocking Home and Away is watched by one and a half million young Australians five days a week, and every one of them feels they know the character Joey Rainbow. SANE Australia approached Channel Seven in 1998 with a proposal to include a storyline about one of the characters developing symptoms of schizophrenia. Most people who develop schizophrenia and other psychotic illnesses are first affected in their teens and early twenties. It's a young persons' illness. Helping people understand this, and that the sooner someone gets psychiatric help the better, are crucial messages for the home and Away audience. In conjunction with the Home and Away story - broadcast early in 1999 - SANE Australia is conducting a national campaign to promote understanding of schizophrenia and the need for early treatment for first and subsequent episodes.   As part of the campaign, SANE Australia has developed a new pamphlet, Understanding Mental Illness: Schizophrenia - the first in a new series - available from GPs as well as directly from SANE.4. "AUSTRALIAN AND NEW ZEALAND PSYCHIATRY AT THE MOVIES" Michael Shortland, Tom Politis, Garry Walter, Alan Rosen The National Mental Health Strategy and the Burdek in Report have highlighted the need for attention to psychiatric stigma, and community surveys have revealed many public misconceptions about people with mental illness. Does the cinema influence psychiatric stigma, or is stigma so deeply ingrained in society that films cannot make a difference either way? Do film makers have a responsibility to teach or

to change attitudes, or should we resign ourselves to the fact that films are essentially entertainment? Possible consequences of cinema depictions of mental illness and psychiatry are described eg. the film "Shine" has perpetuated the myth that parents are the cause of severe mental illness. Is there any good news in film psychiatry? The relatively large number and appeal of recent "psychiatric" films from Australia and New Zealand is encouraging, as are the new messages of hope, resilience, rebellion, self-determination and triumph. In the most recent films, not only are people with mental illness portrayed as real characters capable of expressing the gamut of human emotions, but also a positive stereotype appears to have emerged - the patient as hero or role model. Ignored for so long, psychiatry and mental illness are now the subject of many films produced in Australia and New Zealand. These films should not be rejected simply as "quirky" or "harmless fun", but should be critically appraised to ascertain attitudes to patients, their families, their doctors and mental health professionals. Speaking in a Hippocratic vein, if a "psychiatric" film does no undeserved harm to these stakeholders and also entertains and has artistic merit, this is for the good. If the film is also accurate and informative, challenges prevailing attitudes and transforms your life, so much the better.

159 Paper: COMMUNITY LIVING -DREAMS TO REALITY THE PROJECT 300 EXPERIENCE Gerard Mullen, Jenny Ross-Stephens, Maya Jones Project 300 is a Qld. Initiative which recognises that many people with mental illness living in institutional care can successfully live in the community provided that a range of adequate and appropriate supports are available. This presentation aims to reflect on the lives of some of the 300 people for whom the dream of independent living as part of a community has now become a reality. We will explore from personal accounts given what their dreams were :prior to them being institionalised during institional care upon discharge after prolonged hospitalisation. Project 300 is unique in that its focus has never waivered from encouraging its clients to speak and ask from the heart and attempting through a collaborative service delivery model to fulfil each person's dreams and make them a reality. This presentation will also focus on the issues involved in making dreams come true.